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HEALTH SECURITY ACT

R E P O R T

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ON

H.R. 3600

together with

ADDITIONAL, MINORITY, AND SUPPLEMENTAL VIEWS



JULY 14, 1994.—Ordered to be printed

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JULY 14, 1994.—Ordered to be printed

U.S. GOVERNMENT PRINTING OFFICE

WASHINGTON : 1994

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HEALTH SECURITY ACT

JULY 14, 1994.—Ordered to be printed

Mr. GIBBONS, from the Committee on Ways and Means,
submitted the following

REPORT

together with

ADDITIONAL, MINORITY, AND SUPPLEMENTAL VIEWS

[To accompany H.R. 3600 which on November 20, 1993, was referred jointly to the Committee on Energy and Commerce, to the Committee on Ways and Means, and to the Committee on Education and Labor for consideration of such provisions in titles I, III, VI, VIII, X, and XI and part 1 of subtitle C of title V as fall within its jurisdiction pursuant to clause 1(g) of rule X; and concurrently, for a period ending not later than two weeks after all three committees of joint referral report to the House (or a later time if the Speaker so designates), to the Committee on Armed Services for consideration of subtitle A of title VIII and such provisions of title I as fall within its jurisdiction pursuant to clause 1(c) of rule X, to the Committee on Veterans' Affairs for consideration of subtitle B of title VIII and such provisions of title I as fall within its jurisdiction pursuant to clause 1(u) of rule X, to the Committee on Post Office and Civil Service for consideration of subtitle C of title VIII and such provisions of title I as fall within its jurisdiction pursuant to clause 1(o) of rule X, to the Committee on Natural Resources for consideration of subtitle D of title VIII and such provisions of title I as fall within its jurisdiction pursuant to clause 1(n) of rule X, to the Committee on the Judiciary for consideration of subtitles C through F of title V and such other provisions as fall within its jurisdiction pursuant to clause 1(l) of rule X, to the Committee on Rules for consideration of sections 1432(d), 6006(f), and 9102(e)(5), and to the Committee on Government Operations for consideration of subtitle B of title V and section 5401]

The Committee on Ways and Means, to whom was referred the bill (H.R. 3600) to ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

I. AMENDMENT

The amendment is as follows:

Strike out all after the enacting clause and insert in lieu thereof the following:

SECTION 1. SHORT TITLE; TABLE OF TITLES AND SUBTITLES.

(a) SHORT TITLE.—This Act may be cited as the “Health Security Act”.

(b) TABLE OF TITLES AND SUBTITLES IN ACT.—The following are the titles and subtitles contained in this Act:

TITLE I—UNIVERSAL COVERAGE

TITLE II—INDIVIDUAL AND EMPLOYER RESPONSIBILITIES

Subtitle A—Individual Responsibilities

Subtitle B—Employer Responsibilities

TITLE III—BENEFITS

Subtitle A—Guaranteed National Benefit Package

Subtitle B—Coverage of Outpatient Prescription Drugs and Other Changes in Medicare Benefits

TITLE IV—STATE PROGRAMS

Subtitle A—State Provider Reimbursement Systems

Subtitle B—State Benefit Management Programs

Subtitle C—State Comprehensive Managed Mental Health and Substance Abuse Programs

TITLE V—HEALTH PLANS AND HEALTH ALLIANCES

Subtitle A—Standards for Carriers and Insured Health Benefit Plans

Subtitle B—Standards for Sponsors and Self-Insured Health Benefit Plans

Subtitle C—Standards for Supplemental Health Plans

Subtitle D—Transitional Insurance Reforms

Subtitle E—Health Alliances

TITLE VI—COST CONTAINMENT IN THE PRIVATE SECTOR

Subtitle A—National Health Expenditure Estimates

Subtitle B—State Health Expenditure Estimates

Subtitle C—Stand-By Federal Cost Containment

Subtitle D—Maximum Payment Rates

Subtitle E—Administrative and Judicial Review

Subtitle F—National Health Cost Commission

TITLE VII—PUBLIC HEALTH INITIATIVES

Subtitle A—Health Workforce Priorities

Subtitle B—Additional Provisions Regarding Primary Care

Subtitle C—Essential Health Facilities

Subtitle D—Lead Paint Abatement

Subtitle E—Federal Grants for Managed Care Plans

Subtitle F—Emergency Medical Services in Rural Areas

Subtitle G—Biomedical Research Program Account

Subtitle H—United States-Mexico Border Health Commission

TITLE VIII—MEDICARE AND MEDICAID

Subtitle A—Medicare Part C Program

Subtitle B—Benefits for Low-Income Individuals; State Maintenance of Effort

Subtitle C—Cost Containment in the Medicare Programs

Subtitle D—Additional Medicare Savings

Subtitle E—Minor and Technical Medicare Amendments

TITLE IX—QUALITY AND CONSUMER PROTECTION

Subtitle A—Quality Management and Improvement

Subtitle B—Information Systems and Administrative Simplification

Subtitle C—Fraud and Abuse

Subtitle D—Physician Ownership and Referral

TITLE X—LONG-TERM CARE

Subtitle A—Long-Term Care Program

Subtitle B—Federal Standards for Private Long-Term Care Insurance Policies

TITLE XI—REVENUES

Subtitle A—Increase in Excise Taxes on Tobacco Products

Subtitle B—Treatment of Employer-Provided Health Care

Subtitle C—Extending Medicare Coverage of, and Application of Hospital Insurance Tax to, All State and Local Government Employees

Subtitle D—Treatment of Organizations Providing Health Care Services and Related Organizations

Subtitle E—Treatment of Accelerated Death Benefits Under Life Insurance Contracts

Subtitle F—Employment Status Provisions

Subtitle G—Tax Treatment of Funding of Retiree Health Benefits

Subtitle H—Excise Taxes on Insured and Self-Insured Health Plans

SEC. 2. GENERAL DEFINITIONS.

For purposes of this Act, except as otherwise specifically provided:

(1) **AFDC RECIPIENT.**—The term “AFDC recipient” means, for a month, an individual who is receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A or part E of title IV, of the Social Security Act for the month.

(2) **CLASS OF ENROLLMENT.**—The term “class of enrollment” means a class for enrollment of families specified in section 3(b).

(3) **ELIGIBLE INDIVIDUAL.**—The term “eligible individual” has the meaning given such term in section 1001(c).

(4) **GUARANTEED NATIONAL BENEFIT PACKAGE.**—The term “guaranteed national benefit package” means the package of health benefits described in title XXI of the Social Security Act, as added by section 2001.

(5) **MEDICAID PROGRAM.**—The term “medicaid program” means a State plan for medical assistance approved under title XIX of the Social Security Act.

(6) **MEDICARE PART A BENEFICIARY.**—The term “medicare part A beneficiary” means an individual who is entitled to benefits under part A of the medicare program.

(7) **MEDICARE PART C.**—The term “medicare part C” means the program of health insurance benefits under part A of title XXIII of the Social Security Act (as added by section 8001).

(8) **MEDICARE PROGRAM.**—The term “medicare program” means the programs under title XVIII of the Social Security Act.

(9) **QUALIFIED HEALTH PLAN.**—The term “qualified health plan” means a health plan that is certified (or deemed to be certified) as meeting the requirements of part B or C of title XXII of the Social Security Act, as added by subtitles A and B of title V, and, except as otherwise provided, does not include the medicare program or medicare part C.

(10) **SSI RECIPIENT.**—The term “SSI recipient” means, for a month, an individual—

(A) with respect to whom supplemental security income benefits are being paid under title XVI of the Social Security Act for the month,

(B) who is receiving a supplementary payment under section 1616 of such Act or under section 212 of Public Law 93–66 for the month,

(C) who is receiving monthly benefits under section 1619(a) of the Social Security Act (whether or not pursuant to section 1616(c)(3) of such Act) for the month, or

(D) who is treated under section 1619(b) of the Social Security Act as receiving supplemental security income benefits in a month for purposes of title XIX of such Act.

(11) **SECRETARY.**—The term “Secretary” means the Secretary of Health and Human Services.

(12) **STATE.**—The term “State” means the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

(13) **UNITED STATES.**—The term “United States” means the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and Northern Mariana Islands.

SEC. 3. DEFINITIONS AND RULES RELATING TO FAMILY MEMBERS.

(a) **FAMILY DEFINED.**—In this Act, unless otherwise provided, the term “family”—

(1) means, with respect to an eligible individual who is not a young dependent, the individual; and

(2) includes the following persons (if any):

(A) The individual’s spouse if the spouse is an eligible individual.

(B) The individual’s young dependents (and, if applicable, the young dependents of the individual’s spouse) if they are eligible individuals.

In this section, the term “young dependent” has the meaning given such term in section 59B(e)(5) of the Internal Revenue Code of 1986.

(b) **CLASSES OF ENROLLMENT; TERMINOLOGY.**—In this Act:

(1) **IN GENERAL.**—Each of the following is a separate class of enrollment:

(A) Coverage only of an individual (referred to in this Act as the “individual” enrollment or class of enrollment).

(B) Coverage of an unmarried individual and one or more children (referred to in this Act as the “single parent” enrollment or class of enrollment).

(C) Coverage of a married couple and one or more children (referred to in this Act as the “family” enrollment or class of enrollment).

(2) COUPLES ENROLLED IN DIFFERENT PLANS.—In the case of a couple—

(A) without young dependents in which each spouse is enrolled in a different health plan, each spouse is considered to be enrolled in an individual class of enrollment, and

(B) with young dependents in which a spouse is enrolled in one plan and the other spouse and young dependents are enrolled in another plan, the former spouse is considered to be enrolled in an individual class of enrollment and the latter spouse and young dependents are considered to be enrolled in a single parent class of enrollment.

(c) SPOUSE; MARRIED; COUPLE.—In this Act:

(1) IN GENERAL.—The terms “spouse” and “married” mean, with respect to a person, another individual who is the spouse of the person or married to the person, as determined under applicable State law.

(2) COUPLE.—The term “couple” means an individual and the individual’s spouse.

TITLE I—UNIVERSAL COVERAGE

TABLE OF CONTENTS OF TITLE

Sec. 1001. Entitlement to health benefits.

Sec. 1002. Protection of consumer choice.

SEC. 1001. ENTITLEMENT TO HEALTH BENEFITS.

(a) IN GENERAL.—In accordance with this Act, each eligible individual is entitled to the benefits covered under the guaranteed national benefit package under title III.

(b) HEALTH SECURITY CARD.—Each eligible individual is entitled to be issued a health security card by the qualified health plan (or under the medicare program or medicare part C) in which the individual is enrolled.

(c) ELIGIBLE INDIVIDUAL DEFINED.—

(1) IN GENERAL.—In this Act, the term “eligible individual” means an individual who is—

(A) a citizen or national of the United States;

(B) an alien permanently residing in the United States under color of law (as defined in subsection (e)(1)); or

(C) a long-term nonimmigrant (as defined in subsection (e)(2)).

(2) EXCLUSION.—Such term does not include—

(A) a prisoner, or

(B) an undocumented alien.

(d) TREATMENT OF PART A MEDICARE BENEFICIARIES.—In the case of an individual entitled to benefits under part A of the medicare program, the provision of benefits under that program is deemed, for purposes of subsection (a) and meeting coverage requirements under title III, to constitute an entitlement to benefits covered under the guaranteed national benefit package.

(e) DEFINITIONS.—In this section:

(1) ALIEN PERMANENTLY RESIDING IN THE UNITED STATES UNDER COLOR OF LAW.—The term “alien permanently residing in the United States under color of law” means an alien lawfully admitted for permanent residence (within the meaning of section 101(a)(20) of the Immigration and Nationality Act), and includes any of the following:

(A) An alien who is admitted as a refugee under section 207 of the Immigration and Nationality Act.

(B) An alien who is granted asylum under section 208 of such Act.

(C) An alien whose deportation is withheld under section 243(h) of such Act.

(D) An alien who is admitted for temporary residence under section 210, 210A, or 245A of such Act.

(E) An alien who has been paroled into the United States under section 212(d)(5) of such Act for an indefinite period or who has been granted extended voluntary departure as a member of a nationality group.

(F) An alien who is the spouse or unmarried child under 21 years of age of a citizen of the United States, or the parent of such a citizen if the citizen is over 21 years of age, and with respect to whom an application for adjustment to lawful permanent residence is pending.

(G) An alien within such other classification of permanent resident aliens as the Secretary may establish by regulation.

(2) **LONG-TERM NONIMMIGRANT.**—The term “long-term nonimmigrant” means a nonimmigrant described in subparagraph (E), (H), (I), (K), (L), (N), (O), (Q), or (R) of section 101(a)(15) of the Immigration and Nationality Act.

(3) **PRISONER.**—The term “prisoner” means, as specified by the Secretary, an individual during a period of imprisonment under Federal, State, or local authority after conviction as an adult.

(f) **ADDITIONAL RECOMMENDATIONS AND RULES.**—

(1) **RECOMMENDATIONS CONCERNING ALIENS.**—The Secretary, in consultation with the Attorney General, shall make recommendations to Congress with respect to classes of eligibility for aliens and modifications of rules concerning eligibility and coverage for aliens.

(2) **RULES.**—The Secretary shall consider—

(A) appropriate treatment of diplomatic personnel and employees of international organizations,

(B) appropriate rules for minors who are not dependents of eligible individuals, and

(C) appropriate rules for the treatment of spouses who are dependents of ineligible individuals.

(3) **RECIPROCAL TREATMENT OF OTHER NONIMMIGRANTS.**—With respect to those classes of individuals who are lawful nonimmigrants but who are not long-term nonimmigrants (as defined in subsection (e)(2)), the Secretary, in consultation with the Attorney General, shall submit to Congress such recommendations relating to reciprocal agreements between the United States and foreign states with respect to coverage of some or all classes of such nonimmigrants as may be appropriate.

(g) **EFFECTIVE DATE.**—This section takes effect on January 1, 1998.

SEC. 1002. PROTECTION OF CONSUMER CHOICE.

Nothing in this Act shall be construed as prohibiting the following:

(1) An individual from choosing the individual’s own health care provider.

(2) An individual from purchasing any health care services.

(3) An individual from purchasing supplemental insurance (offered consistent with this Act) to cover health care services not covered under the guaranteed national benefit package.

(4) Employers from providing coverage (consistent with this Act) for benefits in addition to the guaranteed national benefit package.

TITLE II—INDIVIDUAL AND EMPLOYER RESPONSIBILITIES

TABLE OF CONTENTS OF TITLE

Sec. 2001. Amendment of 1986 code.

Subtitle A—Individual Responsibilities

Sec. 2101. Individual share of medicare part C premiums.

Subtitle B—Employer Responsibilities

Sec. 2201. Health-related employer taxes and credits.

Sec. 2202. Reporting requirements.

Sec. 2203. Transitional continuation coverage requirement for group health plans.

Sec. 2204. Taxes on employers failing to meet certain other health coverage-related requirements.

SEC. 2001. AMENDMENT OF 1986 CODE.

Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

Subtitle A—Individual Responsibilities

SEC. 2101. INDIVIDUAL SHARE OF MEDICARE PART C PREMIUMS.

(a) **GENERAL RULE.**—Subchapter A of chapter 1 (relating to determination of tax liability) is amended by adding at the end the following new part:

“PART VIII—INDIVIDUAL SHARE OF MEDICARE PART C PREMIUMS

“Sec. 59B. Individual share of medicare part C premiums.

“SEC. 59B. INDIVIDUAL SHARE OF MEDICARE PART C PREMIUMS.

“(a) IMPOSITION OF TAX.—In the case of an individual, there is hereby imposed (in addition to any other tax imposed by this subtitle) a tax for the taxable year in the amount equal to the medicare part C premium liability (if any) of such individual for such taxable year.

“(b) EXEMPTION FOR LOW-INCOME INDIVIDUALS.—

“(1) IN GENERAL.—No tax shall be imposed by subsection (a) on any taxpayer whose modified adjusted gross income for the taxable year does not exceed the threshold amount.

“(2) PHASE-IN OF TAX.—

“(A) IN GENERAL.—If the modified adjusted gross income of the taxpayer for the taxable year exceeds the threshold amount by less than the phase-in amount, the amount of the tax imposed by subsection (a) for such taxable year shall be the phase-in percentage of the medicare part C premium liability of such taxpayer for such taxable year.

“(B) PHASE-IN PERCENTAGE.—For purposes of subparagraph (A), the phase-in percentage shall be determined under tables prescribed by the Secretary which—

“(i) shall have income brackets of not more than \$50, and

“(ii) provide for a ratable increase in the amount of tax imposed by subsection (a) for modified adjusted gross incomes between the threshold amount and the sum of the threshold amount and the phase-in amount.

“(C) PHASE-IN AMOUNT.—For purposes of subparagraphs (A) and (B), the phase-in amount is the amount equal to the applicable percentage (determined in accordance with the following table) of the threshold amount.

“In the case of taxable years ending with or within—	The applicable percentage is—
1998, 1999, or 2000	100 percent
2001 or 2002	120 percent
2003 or thereafter	140 percent.

“(c) MEDICARE PART C PREMIUM LIABILITY.—For purposes of this section—

“(1) IN GENERAL.—The medicare part C premium liability of any individual for any taxable year is the excess (if any) of—

“(A) the sum of the applicable medicare part C premiums for each month of medicare part C coverage during the taxable year, over

“(B) the sum of—

“(i) the aggregate mandatory employer taxes with respect to the employment of such individual during the calendar year in which the taxable year begins, and

“(ii) the aggregate elective employer taxes with respect to the employment of such individual during such calendar year.

For purposes of this paragraph, the term ‘month of medicare part C coverage’ means any month as of the first day of which the individual, the spouse of the individual, or any young dependent of the individual is a medicare part C covered individual.

“(2) LIMITATION ON MANDATORY EMPLOYER TAXES TAKEN INTO ACCOUNT.—The amount of mandatory employer taxes which are taken into account under paragraph (1)(B)(i) with respect to any individual for any taxable year shall not exceed 80 percent of the amount referred to in paragraph (1)(A).

“(3) APPLICABLE MEDICARE PART C PREMIUM.—

“(A) TAXPAYERS WITH YOUNG DEPENDENTS.—Except as provided in subparagraph (C), if, as of the first day of a month, the individual (or, in the case of a joint return, either spouse) has a young dependent who is a medicare part C covered individual, the applicable medicare part C premium for such month is—

“(i) the applicable family premium for such month in the case of a joint return filed by spouses both of whom are medicare part C covered individuals for such month, and

“(ii) the applicable single parent premium for such month in any other case.

“(B) TAXPAYERS WITHOUT YOUNG DEPENDENTS.—Except as provided in subparagraph (C), if, as of the first day of a month, the individual does not have (or, in the case of a joint return, neither spouse has) a young dependent who is a medicare part C covered individual, the applicable medicare part C premium for such month is—

“(i) the applicable individual premium for such month, or

“(ii) in the case of a joint return, the sum of the applicable individual premiums for each spouse who is a medicare part C covered individual for such month.

“(C) SPOUSES NOT FILING JOINT RETURNS BY REASON OF DIVORCE OR OTHERWISE.—If—

“(i) the individual was married as of the first day of a month,

“(ii) the applicable medicare part C premium for such month would have been the applicable family premium if the individual had filed a joint return for the taxable year which includes such month with the spouse of such individual as of such first day, and

“(iii) the individual does not file a joint return for such taxable year, the applicable medicare part C premium for such month is $\frac{1}{2}$ the applicable family premium.

“(D) APPLICABLE PREMIUMS.—The applicable individual premium, the applicable family premium, and the applicable single parent premium of an individual for any month shall be determined—

“(i) under tables prescribed under section 2321(a) of the Social Security Act by the Secretary of Health and Human Services which are effective for such month, and

“(ii) on the basis of the State (or place outside the United States) in which such individual has his principal place of abode as of the first day of such month.

“(d) MEDICARE PART C COVERED INDIVIDUAL.—For purposes of this section—

“(1) IN GENERAL.—An individual shall be treated as a medicare part C covered individual for any month unless—

“(A) for such month, such individual is covered under a qualified health plan or medicare part A, and

“(B) such individual furnishes to the Secretary (at such time and in such manner as the Secretary may prescribe) the required certification of such coverage for such month.

“(2) QUALIFIED HEALTH PLAN.—

“(A) IN GENERAL.—The term ‘qualified health plan’ has the meaning given such term by section 2 of the Health Security Act.

“(B) CERTAIN OTHER PLANS INCLUDED.—The term ‘qualified health plan’ includes any State benefit management program approved under subtitle B of title IV of the Health Security Act.

“(3) MEDICARE PART A.—The term ‘medicare part A’ means the insurance program established by part A of title XVIII of the Social Security Act.

“(e) OTHER DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

“(1) THRESHOLD AMOUNT.—

“(A) IN GENERAL.—Except as provided in subparagraph (B), the term ‘threshold amount’ means—

“(i) \$7,400 in the case of a return with respect to which 1 personal exemption is allowable under section 151,

“(ii) \$11,500 in the case of a return with respect to which 2 or 3 personal exemptions are allowable under section 151, and

“(iii) \$16,000 in the case of a return with respect to which 4 or more personal exemptions are allowable under section 151.

“(B) CERTAIN SEPARATE RETURNS.—The threshold amount shall be zero in the case of a taxpayer who—

“(i) is married as of the close of the taxable year but does not file a joint return for such taxable year, and

“(ii) does not live apart from his spouse at all times during the last 6 months of the taxable year.

“(C) INFLATION ADJUSTMENTS.—In the case of a taxable year beginning in a calendar year after 1997, each dollar amount contained in subparagraph (A) shall be increased by an amount equal to—

“(i) such dollar amount, multiplied by

“(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, by substituting ‘calendar year 1994’ for ‘calendar year 1992’ in subparagraph (B) thereof.

“(2) MODIFIED ADJUSTED GROSS INCOME.—The term ‘modified adjusted gross income’ means adjusted gross income—

“(A) determined without regard to sections 911, 931, and 933, and

“(B) increased by the amount of interest received or accrued by the individual during the taxable year which is exempt from tax.

The determination under the preceding sentence shall be made without regard to any carryover or carryback.

“(3) MANDATORY EMPLOYER TAXES.—The term ‘mandatory employer taxes’ means the tax imposed by section 3455 determined without regard to any election under section 3455(b)(2).

“(4) ELECTIVE EMPLOYER TAXES.—The term ‘elective employer taxes’ means the taxes imposed by section 3455 which are not mandatory employer taxes.

“(5) YOUNG DEPENDENT.—The term ‘young dependent’ means, with respect to periods in any calendar year, any individual if—

“(A) an exemption is allowable under section 151(c) with respect to such individual to the taxpayer for a taxable year beginning in such calendar year, and

“(B) such individual—

“(i) has not attained the age of 19 as of the close of such calendar year, or

“(ii) is a student (as defined in section 151(c)(4)) who has not attained age 24 as of the close of such calendar year.

“(6) REQUIRED CERTIFICATION.—The term ‘required certification’ means the statement required to be provided under section 6050Q(b) (or a copy thereof) or any other statement approved by the Secretary for purposes of this section.

“(7) ALLOCATION OF EMPLOYER’S SHARE OF PREMIUMS FOR SPOUSES NOT FILING JOINT RETURN.—Individuals who are married to each other as of the first day of any month and who do not file a joint return with each other for the taxable year which includes such month may allocate mandatory and elective employer taxes for such month to such extent and subject to such conditions as the Secretary shall prescribe.

“(f) COORDINATION WITH OTHER PROVISIONS.—

“(1) TREATMENT AS MEDICAL EXPENSE.—For purposes of section 213, the tax imposed by this section for any taxable year shall be treated as an expense paid during such taxable year for medical care of the taxpayer.

“(2) NOT TREATED AS TAX FOR CERTAIN PURPOSES.—The tax imposed by this section shall not be treated as a tax imposed by this chapter for purposes of determining—

“(A) the amount of any credit allowable under this chapter, or

“(B) the amount of the minimum tax imposed by section 55.

“(3) TREATMENT UNDER SUBTITLE F.—For purposes of subtitle F, the tax imposed by this section shall be treated as if it were a tax imposed by section 1.

“(4) TAXES IMPOSED BY POSSESSIONS.—The tax imposed by this section shall not apply to a bona fide resident of a possession with respect to which the requirements of section 2301(c)(3)(A) of the Social Security Act are met.

“(g) EXEMPTIONS.—

“(1) IN GENERAL.—No tax shall be imposed by this section on any individual for any taxable year if such individual is—

“(A) a young dependent of any taxpayer for a taxable year of such taxpayer which begins in the calendar year in which such taxable year begins,

“(B) a nonresident alien, or

“(C) for each month of such taxable year—

“(i) a member of a family receiving aid under a State plan approved under part A or E of title IV of the Social Security Act, or

“(ii) an SSI recipient (as defined in section 2 of the Health Security Act).

Subparagraph (C)(ii) shall not apply to an individual filing a joint return unless both spouses are SSI recipients (as so defined).

“(2) CERTAIN INDIVIDUALS NOT TAKEN INTO ACCOUNT IN DETERMINING AMOUNT OF TAX.—For purposes of this section, an individual shall be treated as not being a medicare part C covered individual for any month if—

“(A) the first day of such month is included in any period for which such individual is a qualified individual (as defined in section 911(d)(1)),

“(B) as of the first day of such month, there is in effect for such individual—

“(i) a qualified religious exemption (as defined in section 3465(c)(1)), or

“(ii) a qualified disabled veteran exemption (as defined in section 3465(c)(2)),

“(C) as of the first day of such month, such individual is on active duty as a member of the uniformed services (as defined in section 101 of title 10, United States Code), or

“(D) as of the first day of such month, such individual is imprisoned under Federal, State, or local authority.

“(3) SPECIAL RULE FOR INDIVIDUALS RESIDING ABROAD WHO RECEIVE MEDICARE PART C SERVICES.—Paragraph (2)(A) shall not apply to any individual for any taxable year if, at any time during such taxable year, such individual receives services under medicare part C (as defined in section 3467).

“(h) REGULATIONS.—The Secretary may prescribe such regulations as may be appropriate to carry out the purposes of this section, including—

“(1) regulations determining the applicable premium for spouses having different principal places of abode, and

“(2) regulations, prescribed after consultation with the Secretary of Health and Human Services, treating health plans of foreign governments or foreign employers outside the United States as qualified health plans.”

(b) ADJUSTMENTS TO WITHHOLDING.—Subsection (a) of section 3402 (relating to income tax collected at source) is amended by adding at the end the following new paragraph:

“(3) SPECIAL RULE FOR TAX IMPOSED BY SECTION 59B.—

“(A) IN GENERAL.—In determining the amount required to be deducted and withheld from wages paid to an individual during any month by such individual’s employer, the tax imposed by section 59B shall be taken into account.

“(B) WAGES NOT REDUCED BY EXEMPTIONS.—In determining the amount to be deducted and withheld by reason of subparagraph (A), the amount of wages shall not be reduced as provided in paragraph (2).”

(c) RELIEF FROM ESTIMATED TAX PENALTIES WHERE EMPLOYMENT TERMINATED.—Paragraph (3) of section 6654(e) (relating to failure by individual to pay estimated income tax) is amended by adding at the end the following new subparagraph:

“(C) UNDERPAYMENT OF MEDICARE PART C PREMIUMS FOR MONTHS AFTER INVOLUNTARY TERMINATION OF EMPLOYMENT.—If the Secretary determines that—

“(i) an individual’s employment was involuntarily terminated during the taxable year, and

“(ii) the medicare part C portion of any underpayment for such year was due to reasonable cause and not due to willful neglect, no addition to tax shall be imposed under subsection (a) with respect to such portion. For purposes of the preceding sentence, the medicare part C portion of an underpayment is the amount of the underpayment to the extent that it does not exceed the amount of the tax imposed by section 59B which is attributable to the portion of such taxable year after such termination.”

(d) TECHNICAL AMENDMENTS.—

(1) Subsection (a) of section 6012 is amended by inserting after paragraph (9) the following new paragraph:

“(10) Every individual if—

“(A) such individual, or the spouse or any young dependent (as defined in section 59B(e)(5)) of such individual, is a medicare part C covered individual (as defined in section 59B(d)) for any month in the taxable year, and

“(B) such individual is not exempt from the tax imposed by section 59B by reason of subsection (b)(1) or (g) thereof.”

(2) Section 31 is amended by adding at the end the following new subsection:

“(d) CERTAIN PAYMENTS OF MEDICARE PART C PREMIUMS.—The amount paid by an individual to the Secretary of Health and Human Services under section 2323(b) of the Social Security Act shall be allowed to such individual as a credit against the tax imposed by this subtitle for the taxable year which includes the month for which such amount was required to be paid. Individuals who are married to each other as of the first day of any month and who do not file a joint return with each other for the taxable year which includes such month may allocate the amounts described in the preceding sentence for such month to such extent and subject to such conditions as the Secretary shall prescribe.”

(3) Subparagraph (A) of section 1(f)(6) is amended by inserting “section 59B(e)(1)(C),” after paragraph (2)(A).”

(4)(A) Subsection (b) of section 6521 is amended to read as follows:

“(b) INDIVIDUAL AND EMPLOYER MEDICARE PART C PREMIUMS.—In the case of the tax imposed by section 59B (relating to individual share of medicare part C premiums) and the tax imposed by section 3455 (relating to employer share of medicare part C premiums), if—

“(1) an amount is erroneously treated under section 59B as the medicare part C premium liability of an individual, or an amount is erroneously treated under section 3455 as the employer share of the applicable medicare part C premium with respect to such individual,

“(2) the correction of the error would require an assessment of one such tax and the refund or credit of the other tax, and

“(3) at any time the correction of the error is authorized as to one such tax but is prevented as to the other tax by any law or rule of law (other than section 7122, relating to compromises),

then, if the correction authorized is made, the amount of the assessment, or the amount of the credit or refund, as the case may be, authorized as to the one tax shall be reduced by the amount of the credit or refund, or the amount of the assessment, as the case may be, which would be required with respect to such other tax for the correction of the error if such credit or refund, or such assessment, of such other tax were not prevented by any law or rule of law (other than section 7122, relating to compromises).”

(B) Subsection (a) of section 6521 is amended by adding at the end the following new sentence: “For purposes of this subsection, the terms ‘self-employment income’ and ‘wages’ shall have the same meanings as when used in section 1402(b).”

(e) CLERICAL AMENDMENT.—The table of parts for subchapter A of chapter 1 is amended by adding at the end the following new item:

“Part VIII. Individual share of medicare part C premiums.”

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to months beginning after December 31, 1997, in taxable years ending after such date.

Subtitle B—Employer Responsibilities

SEC. 2201. HEALTH-RELATED EMPLOYER TAXES AND CREDITS.

(a) GENERAL RULE.—Subtitle C (relating to employment taxes) is amended by redesignating chapter 25 as chapter 26 and by inserting after chapter 24 the following new chapter:

“CHAPTER 25—HEALTH-RELATED EMPLOYER TAXES AND CREDITS

“Subchapter A. Employer Taxes.

“Subchapter B. Employer Credits.

“Subchapter C. General Provisions.

“Subchapter A—Employer Taxes

“Part I. Tax on noncomplying large employers.

“Part II. Employer share of medicare part C premiums.

“Part III. Tax with respect to employees covered by certain other health plans.

“PART I—TAX ON NONCOMPLYING LARGE EMPLOYERS

“Sec. 3451. Imposition of tax.

“SEC. 3451. IMPOSITION OF TAX.

“(a) IMPOSITION OF TAX.—In addition to other taxes, there is hereby imposed on every large employer an excise tax, with respect to the employment of any employee during any month unless, for such month—

“(1) such employee is a qualified employer-covered employee of such employer,

or

“(2) such employee is a voluntarily excluded employee.

“(b) AMOUNT OF TAX.—The amount of the tax imposed by subsection (a) with respect to any employee for any month shall be an amount equal to 25 percent of the wages paid during such month by such employer to such employee.

“(c) TAX NOT TO APPLY TO EMPLOYMENT OF CERTAIN EMPLOYEES.—

“(1) EMPLOYEES PERMITTED TO BE EXCLUDED FROM COVERAGE UNDER PRIVATE EMPLOYER PLANS.—No tax shall be imposed by this section on the employment for any month of any of the following employees:

“(A) CERTAIN PART-TIME EMPLOYEES.—Any employee whose normal work week is reasonably expected as of the 1st day of such month to be less than 25 hours.

“(B) SEASONAL OR TEMPORARY EMPLOYEES.—Any employee who is not reasonably expected as of the 1st day of such month to be employed by the employer for a period of 120 consecutive days during any 365-day period that includes such 1st day.

“(C) DELAY FOR CERTAIN PART-TIME EMPLOYEES.—Any employee whose normal work week is reasonably expected as of the 1st day of such month to be at least 25 hours, but less than 35 hours, and the normal work week of the employee during the preceding 3 months was less than 25 hours.

“(2) GENERALLY EXCLUDABLE EMPLOYEES.—

“For exemption from tax for employment of generally excludable employees, see section 3465.

“(d) DEFINITIONS.—For purposes of this section—

“(1) LARGE EMPLOYER.—

“(A) IN GENERAL.—The term ‘large employer’ means, with respect to any calendar year, any employer if, on each of 20 days during the preceding calendar year (each day being in a different week), such employer (or any predecessor) employed more than 100 employees for some portion of the day.

“(B) AGGREGATION RULES.—For purposes of subparagraph (A)—

“(i) all employers treated as a single employer under subsection (a) or (b) of section 52 shall be treated as a single employer, and

“(ii) all employees of the members of an affiliated service group (as defined in section 414(m)) shall be treated as employed by a single employer.

“(2) VOLUNTARILY EXCLUDED EMPLOYEE.—The term ‘voluntarily excluded employee’ means, with respect to a month, any of the following employees if the employee was offered coverage in accordance with section 3466(c):

“(A) OTHER HEALTH COVERAGE.—Any employee if there is in effect as of the first day of such month a withholding exemption certificate stating that such employee is covered under medicare part A or a qualified health plan other than a plan of such employer.

“(B) INDIVIDUALS ELECTING MEDICARE PART C.—Any employee if there is in effect as of the first day of such month a withholding exemption certificate stating that such employee—

“(i) is an eligible individual (as defined in section 1001(c) of the Health Security Act) described in section 2301(b)(4) of the Social Security Act, and

“(ii) waives coverage under all qualified health plans of the employer for such month.

“(C) WAIVER DURING TRANSITION PERIOD.—In the case of a month before January 1998, any employee who waives coverage under all qualified health plans of the employer for such month.

“(e) WAIVER OF TAX IN CERTAIN CASES.—If—

“(1) a large employer failed—

“(A) to correctly determine that it is a large employer, or

“(B) to cover any employee as a qualified employer-covered employee of such employer (other than an employee referred to in paragraph (1) or (2) of subsection (c)),

“(2) such failure is due to reasonable cause and not to willful neglect, and

“(3) the employer takes such corrective action as the Secretary may require, the Secretary may waive part or all of the tax imposed by subsection (a) if the Secretary determines that the payment of such tax would be excessive relative to the failure involved.

“PART II—EMPLOYER SHARE OF MEDICARE PART C PREMIUMS

“Sec. 3455. Imposition of tax.

“SEC. 3455. IMPOSITION OF TAX.

“(a) IMPOSITION OF TAX.—In addition to other taxes, there is hereby imposed on every employer an excise tax, with respect to the employment of any medicare part C covered employee during any calendar month, equal to the employer share of the applicable medicare part C premium for such month.

“(b) EMPLOYER SHARE OF MEDICARE PART C PREMIUM.—For purposes of subsection (a)—

“(1) IN GENERAL.—The employer share of the applicable medicare part C premium for any calendar month is an amount equal to 80 percent of the applicable medicare part C premium for such month.

“(2) EMPLOYER ELECTION TO INCREASE SHARE.—At the election of the employer, paragraph (1) shall be applied by substituting for ‘80 percent’ any percentage specified by the employer which is greater than 80 percent and not greater than 100 percent. Any percentage so specified shall apply to the month for which made and all succeeding months beginning before the date it is revoked by the employer. Any percentage so specified shall apply to all medicare part C covered employees of such employer.

“(3) REDUCTION FOR PART-TIME EMPLOYEES.—

“(A) IN GENERAL.—In the case of any part-time employee (as defined in section 3467), the employer share of the applicable medicare part C premium for any month is the applicable fraction (as defined in section 3467) of the amount determined under paragraphs (1) and (2).

“(B) EMPLOYER ELECTION TO INCREASE SHARE.—Any employer may elect to specify, with respect to any part-time employee for any month, an applicable fraction which is greater than the applicable fraction which would (but for this subparagraph) apply to such employee for such month but not greater than 1. Any fraction so specified shall apply to such employee for the month for which made and all succeeding months beginning before the date it is revoked by the employer.

“(c) APPLICABLE MEDICARE PART C PREMIUM.—For purposes of this section—

“(1) IN GENERAL.—Except as otherwise provided in this subsection, the applicable medicare part C premium for a medicare part C covered employee for any month is the applicable individual premium for such month.

“(2) EMPLOYEES WITH YOUNG DEPENDENTS.—If, for any month, an employee has a young dependent who is not covered by a qualified health plan or medicare part A—

“(A) IN GENERAL.—Except as provided in subparagraph (B), the applicable medicare part C premium for such employee for such month is—

“(i) the applicable family premium for such month if such employee is married and both spouses are not covered by any qualified health plan or medicare part A, and

“(ii) the applicable single parent premium for such month in any other case.

“(B) FULL FAMILY PREMIUM PAID BY ANOTHER EMPLOYER.—If, for such month, another employer pays an unreduced applicable family premium for such month with respect to such employee or the spouse of such employee, the applicable medicare part C premium for such employee for such month is zero. For purposes of this subparagraph, the term ‘unreduced’ means, with respect to any premium, a premium which is not reduced under subsection (b)(3).

“(3) EMPLOYEES WITH SPOUSES FOR WHOM NO EMPLOYER PAYS PART C PREMIUM.—If, for any month—

“(A) an employee is married but does not have a young dependent who is not covered by a qualified health plan or medicare part A,

“(B) neither such employee nor such employee’s spouse is covered by a qualified health plan or medicare part A, and

“(C) no other employer pays the employer’s share of an unreduced (as defined in paragraph (2)(B)) applicable medicare part C premium for such spouse for such month,

then the applicable medicare part C premium for such employee for such month is twice the applicable individual premium for such month.

“(4) APPLICABLE PREMIUMS.—The applicable individual premium, the applicable family premium, and the applicable single parent premium of an employee for any month shall be determined—

“(A) under tables prescribed under section 2321(a) of the Social Security Act by the Secretary of Health and Human Services which are effective for such month, and

“(B) on the basis of the State or place outside the United States (which such employee certifies in the withholding exemption certificate which is in effect as of the first day of such month) in which such employee has his principal place of abode.

“(5) CERTAIN INDIVIDUALS NOT TAKEN INTO ACCOUNT IN DETERMINING AMOUNT OF TAX.—An individual who is married to an individual described in subparagraph (B), (C), or (D) of section 59B(g)(2) shall be treated as not married for purposes of this subsection.

“(6) FAILURE TO DISCLOSE PRINCIPAL PLACE OF ABODE.—If an employee does not have in effect with his employer a withholding exemption certificate which certifies the employee's principal place of abode, such employee's principal place of abode shall be treated for purposes of paragraph (4)(B) as being in the State which includes such employee's principal place of employment with his employer.

“(7) DETERMINATIONS MADE ON BASIS OF WITHHOLDING CERTIFICATE.—Determinations of the applicable medicare part C premium for an employee for any month shall be made on the basis of such employee's withholding exemption certificate (if any) which is in effect as of the first day of such month unless the employer has actual knowledge that the information provided on such certificate is incorrect.

“(d) DEFINITIONS.—For purposes of this section—

“(1) MEDICARE PART C COVERED EMPLOYEE.—An employee of the employer shall be treated as a medicare part C covered employee for any month unless—

“(A)(i) such employee is a qualified employer-covered employee of such employer for such month, or

“(ii) there is in effect as of the first day of such month a withholding exemption certificate stating that such employee is covered under a qualified health plan (other than a plan of such employer) or medicare part A, and

“(B)(i) each young dependent (if any) of such employee is covered for such month under the qualified health plan of the employer under which such employee is covered, or

“(ii) there is in effect as of the first day of such month a withholding exemption certificate stating that each young dependent (if any) of such employee is covered under a plan described in subparagraph (A)(ii).

“(2) YOUNG DEPENDENT.—The term ‘young dependent’ has the meaning given such term by section 59B(e)(5).

“(3) EMPLOYEE.—For purposes of this section, the term ‘employee’ includes a former employee of an employer if the requirements of section 4980C(g) apply to such employer and the employer elects to satisfy such requirements as described in section 4980C(g)(2)(B).

“(e) CREDIT FOR TAXES PAID BASED ON INCORRECT INFORMATION.—If—

“(1) on or before January 31 of any calendar year, an employer determines (in such manner as the Secretary shall prescribe) that such employer overpaid the tax imposed by this section with respect to an employee for any month during the preceding calendar year by reason of incorrect information shown on any withholding exemption certificate of such employee which was in effect for such month, and

“(2) the statement furnished to such employee under section 6051 on or before such January 31 for the preceding calendar year reflects the tax which would have been paid by such employer if the information shown on such certificate had been correct,

then the excess of the tax paid under this section by such employer during such preceding calendar year over the amount of tax referred to in paragraph (2) shall be treated as an overpayment of the tax.

“(f) TAX TREATED AS EMPLOYER-PROVIDED HEALTH COVERAGE.—

“(1) INCOME TAX.—For purposes of chapter 1, payment of the taxes imposed by this section shall be treated as the providing of coverage by the employer under an accident or health plan.

“(2) EMPLOYMENT TAXES.—For purposes of this subtitle, no amount shall be included in the remuneration of any individual by reason of the payment of the taxes imposed by this section.

“PART III—TAX WITH RESPECT TO EMPLOYEES COVERED BY CERTAIN OTHER HEALTH PLANS

“Sec. 3458. Imposition of tax.

“SEC. 3458. IMPOSITION OF TAX.

“(a) IMPOSITION OF TAX.—In addition to other taxes, there is hereby imposed on every employer an excise tax, with respect to the employment of any employee described in subsection (b) during any month, equal to 80 percent of the applicable individual premium (as defined in section 3455(c)(4)) for such month with respect to each such employee. In applying section 3455(c)(4) for purposes of the preceding sentence, such employee’s principal place of abode shall be treated as being in the State which includes such employee’s principal place of employment with such employer.

“(b) EMPLOYEES DESCRIBED.—For purposes of subsection (a), an employee is described in this subsection for any month if—

“(1) such employee is covered for such month under a qualified health plan other than a plan of his employer and (but for such coverage) such employer would be liable for tax under section 3451 or 3455 with respect to the employment of such employee for such month, or

“(2) such employee is a medicare part C covered individual (as defined in section 59B(d)) for such month, and the applicable medicare part C premium for such employee is zero by reason of section 3455(c)(2)(B).

For purposes of paragraph (1), it shall be assumed that the employee would not become a qualified employer-covered employee of his employer.

“(c) REDUCTION OF TAX FOR PART-TIME EMPLOYEES.—With respect to any part-time employee, the tax imposed by this section for any month shall be an amount equal to the applicable fraction of the amount determined under subsection (a).

“Subchapter B—Employer Credits

“Sec. 3461. Family premium credit.

“Sec. 3462. Small employer credit.

“SEC. 3461. FAMILY PREMIUM CREDIT.

“(a) GENERAL RULE.—Every employer shall be entitled to treat an amount equal to the applicable percentage of such employer’s family premium amount for any calendar quarter as a payment by such employer of such employer’s employment tax liability for such calendar quarter.

“(b) FAMILY PREMIUM AMOUNT.—

“(1) IN GENERAL.—For purposes of this section, the family premium amount of an employer for any calendar quarter is an amount equal to the sum of—

“(A) such employer’s aggregate liability for tax under section 3455 for such quarter with respect to employees for whom the applicable medicare part C premium is the applicable family premium, and

“(B) the aggregate imputed part C family premiums for such quarter for qualified employer-covered employees of such employer receiving family coverage under any qualified health plan of such employer.

“(2) PART C FAMILY PREMIUM LIABILITY.—The determination under paragraph (1)(A) shall be made without regard to any election under section 3455(b)(2).

“(3) IMPUTED PART C FAMILY PREMIUM.—

“(A) IN GENERAL.—For purposes of paragraph (1)(B), the imputed part C family premium for any qualified employer-covered employee is an amount equal to 80 percent of the applicable family premium determined under section 3455 on the basis of the State which includes such employee’s principal place of employment with his employer.

“(B) LOWER PERCENTAGE IN CERTAIN CASES.—If, in determining the amount of the employer contribution to any qualified health plan of such employer with respect to any part-time employee who is a qualified employer-covered employee, the applicable fraction applied by the employer is less than 1, the imputed part C family premium for such employee is such fraction of the amount determined under subparagraph (A).

“(c) APPLICABLE PERCENTAGE.—For purposes of this section—

“(1) IN GENERAL.—The applicable percentage for any calendar year is the percentage which the Secretary estimates (in consultation with the Secretary of Health and Human Services) will result in the aggregate amount of the deemed payments determined under this section for all employers for such year being equal to the product of the phase-in percentage and the Secretary’s estimate of

the taxes imposed by section 3458 which will be paid for such year. Proper adjustments shall be made in the applicable percentage determined for succeeding calendar years to the extent that the applicable percentage determined for such calendar year was greater than or less than the correct percentage.

“(2) PHASE-IN PERCENTAGE.—For purposes of paragraph (1), the phase-in percentage is—

“(A) 25 percent for calendar years 1998 and 1999,

“(B) 40 percent for calendar year 2000,

“(C) 60 percent for calendar year 2001, and

“(D) 100 percent for calendar years after 2001.

“(d) COORDINATION WITH DEPOSITORY REQUIREMENTS.—Any employer who is entitled to treat any amount as a payment under subsection (a) for any calendar quarter may reduce, in such manner as the Secretary may by regulations prescribe, by a like amount, the amount otherwise required to be deposited during such quarter by reason of the employment tax liability of such employer.

“(e) SPECIAL RULES.—

“(1) PAYMENT TREATED AS MADE ON DUE DATE.—Notwithstanding subsection (d), for purposes of determining interest, any deemed payment under subsection (a) for any calendar quarter shall be treated as made on the due date for the return for such quarter.

“(2) DENIAL OF DEDUCTION.—The amount of any deduction otherwise allowable under chapter 1 for the taxes imposed by this chapter or for expenditures under any qualified health plan of such employer shall be reduced by any payment treated as made under subsection (a).

“(f) EMPLOYMENT TAX LIABILITY.—For purposes of this section, the term ‘employment tax liability’ means liability for the taxes imposed by this chapter and chapters 21 and 24.

“SEC. 3462. SMALL EMPLOYER CREDIT.

“(a) GENERAL RULE.—Every eligible small employer shall be entitled to treat an amount equal to the applicable percentage of such employer’s total premium amount for any calendar year as a payment by such employer of such employer’s employment tax liability (as defined in section 3461(f)) for such calendar year.

“(b) TOTAL PREMIUM AMOUNT.—

“(1) IN GENERAL.—For purposes of this section, the total premium amount of an employer for a calendar year is an amount equal to the excess of—

“(A) the sum of—

“(i) such employer’s aggregate liability for tax under sections 3455 and 3458 for such year, and

“(ii) the aggregate imputed part C premiums for such year for qualified employer-covered employees of such employer receiving coverage under any qualified health plan of such employer, over

“(B) the aggregate deemed payments by the employer for such year under section 3461.

“(2) IMPUTED PART C PREMIUM.—For purposes of paragraph (1), the imputed part C premium for any qualified employer-covered employee is an amount equal to 80 percent of the applicable medicare part C premium determined under section 3455 for such employee on the basis of the State which includes such employee’s principal place of employment with his employer and the type of coverage provided to such employee under the qualified health plan. Rules similar to the rules of section 3461(b)(3)(B) shall apply for purposes of the preceding sentence.

“(3) CERTAIN INDIVIDUALS NOT TAKEN INTO ACCOUNT.—The total premium amount of an employer shall be determined without regard to—

“(A) in the case of an employer which is a corporation, any employee who owns (directly or by application of section 318) more than 10 percent of—

“(i) the outstanding stock of such corporation, or

“(ii) the total combined voting power of all stock of the corporation,

“(B) in the case of an employer which is an estate or trust, any grantor, beneficiary, or fiduciary of the estate or trust, and

“(C) any member of the family (within the meaning of section 267(c)(4)) of—

“(i) an individual described in subparagraph (A) or (B),

“(ii) in the case of an employer which is a sole proprietorship, the sole proprietor, or

“(iii) in the case of an employer which is a partnership, any partner who owns more than 10 percent of the capital interest or profits interest of such partnership.

In the case of an employer who is not a corporation, the total premium amount also shall be determined without regard to any individual not performing services in a trade or business of the employer.

"(c) APPLICABLE PERCENTAGE.—For purposes of this section—

"(1) IN GENERAL.—Except as otherwise provided in this subsection, the applicable percentage is—

"(A) 37.5 percent for calendar years after 1997 and before 2003,

"(B) 20 percent for calendar year 2003,

"(C) 10 percent for calendar year 2004, and

"(D) 0 for calendar years after 2004.

"(2) SMALLER EMPLOYERS.—In the case of an employer who would be an eligible small employer if '25 employees' were substituted for '50 employees' in subsection (d)(1), the applicable percentage is—

"(A) 50 percent for calendar years after 1997 and before 2003,

"(B) 30 percent for calendar year 2003,

"(C) 15 percent for calendar year 2004, and

"(D) 0 for calendar years after 2004.

"(3) PHASEOUT OF CREDIT WHERE HIGHER AVERAGE EMPLOYEE WAGE.—If the average employee wage of an eligible small employer for any calendar year exceeds \$12,000, the applicable percentage which would (but for this paragraph) apply for such calendar year shall be reduced (but not below zero) by the number of percentage points which bears the same ratio to such applicable percentage as such excess bears to \$14,000.

"(d) ELIGIBLE SMALL EMPLOYER.—For purposes of this section—

"(1) IN GENERAL.—The term 'eligible small employer' means, with respect to any calendar year, any employer unless—

"(A) on each of 20 days during such year (each day being in a different week), such employer (or any predecessor) employed more than 50 employees for some portion of the day, or

"(B) the average employee wage of such employer for such year exceeds \$26,000.

"(2) AVERAGE EMPLOYEE WAGE.—The average employee wage of an employer for any calendar year is an amount equal to—

"(A) the total payroll of such employer for such calendar year, divided by

"(B) the number of full-time equivalent employees of such employer for such calendar year.

"(3) TOTAL PAYROLL.—The total payroll of an employer for any calendar year is an amount equal to the sum of—

"(A) the total wages paid by the employer during such calendar year,

"(B) in the case of a sole proprietorship, the net earnings from self-employment of the proprietor from such trade or business for the taxable year ending with or within such calendar year, and

"(C) in the case of a partnership, the net income of the partnership for the taxable year ending with or within such calendar year which will be treated as net earnings from self-employment by the partners.

"(4) NET EARNINGS FROM SELF-EMPLOYMENT.—The term 'net earnings from self-employment' has the meaning given such term by section 1402; except that the amount thereof may never be less than zero.

"(5) FULL-TIME EQUIVALENT EMPLOYEES.—The number of full-time equivalent employees of an employer for any calendar year is the sum of—

"(A) the number of employees who worked on a substantially full-time basis for the employer throughout the calendar year, and

"(B) a fraction for each other employee based on the number of hours such employee worked during the calendar year compared to a full-time, full-year employee.

For purposes of this paragraph, the proprietor shall be treated as an employee of a sole proprietorship, and each partner who has net earnings from self-employment from a partnership shall be treated as an employee of such partnership.

"(6) AGGREGATION RULES.—For purposes of this subsection—

"(A) all employers treated as a single employer under subsection (a) or (b) of section 52 shall be treated as a single employer, and

"(B) all employees of the members of an affiliated service group (as defined in section 414(m)) shall be treated as employed by a single employer.

"(e) COORDINATION WITH DEPOSITORY REQUIREMENTS.—

"(1) IN GENERAL.—Any employer who reasonably expects to be entitled to treat any amount as a payment under subsection (a) for any calendar year may reduce, in such manner as the Secretary may by regulations prescribe, by a like

amount, the amount otherwise required to be deposited during such year by reason of the employment tax liability (as defined in section 3461(f)) of such employer.

“(2) QUARTERLY DETERMINATIONS.—The amount of reduction permitted under paragraph (1) for any calendar quarter shall be based on a separate estimate for such quarter of the amount of deemed payments to which the employer reasonably expects to be entitled under subsection (a) for the calendar year which includes such quarter and shall be properly adjusted (under regulations prescribed by the Secretary) to reflect the amount by which prior reductions under subsection (a) during such calendar year were in excess of, or less than, the amounts which would be proper under such estimate.

“(3) YEAR-END ADJUSTMENTS.—

“(A) EXCESS OF DEEMED PAYMENTS ALLOWABLE OVER DEPOSITORY BENEFIT CLAIMED.—If the amount of deemed payments to which an employer is entitled under subsection (a) for any calendar year exceeds the amount claimed by the employer under paragraph (1) during such year, such excess shall be treated for purposes of this title as an overpayment made by such employer. For purposes of determining interest, such overpayment shall be treated as made on January 31 of the following calendar year.

“(B) DEPOSITORY BENEFIT CLAIMED EXCEEDS DEEMED PAYMENT ALLOWABLE.—If the amount claimed by the employer under paragraph (1) during the calendar year exceeds the amount of deemed payments to which such employer is entitled under subsection (a) for such year, such excess shall be treated for purposes of this title as an underpayment of the tax imposed by this chapter for such calendar year. For purposes of determining interest, such underpayment shall be allocated ratably among the calendar quarters in such year (or in such other manner as the Secretary may by regulations prescribe).

“(f) SPECIAL RULES.—

“(1) PAYMENT TREATED AS MADE ON DUE DATE.—Notwithstanding subsection (e), for purposes of determining interest, a payment shall be treated as made under subsection (a) on the due date for the return for each calendar quarter in an amount equal to the amount of the reduction permitted under subsection (e) for such quarter.

“(2) DENIAL OF DEDUCTION.—The amount of any deduction otherwise allowable under chapter 1 for the taxes imposed by this chapter or for expenditures under any qualified health plan of such employer shall be reduced by any payment treated as made under subsection (a).

“Subchapter C—General Provisions

“Sec. 3465. Generally excludable employees.

“Sec. 3466. Qualified employer-covered employees.

“Sec. 3467. Other definitions and special rules.

“SEC. 3465. GENERALLY EXCLUDABLE EMPLOYEES.

“(a) IN GENERAL.—No tax shall be imposed by subchapter A with respect to the employment of any employee during any month if such employee is a generally excludable employee for such month.

“(b) GENERALLY EXCLUDABLE EMPLOYEE.—For purposes of this chapter, the term ‘generally excludable employee’ means any employee for any month if—

“(1) such employee began work for the employer after the first day of such month,

“(2) there is in effect as of the first day of such month a withholding exemption certificate stating that such employee reasonably expects to be a young dependent (as defined in section 59B(e)(5)) of any taxpayer for the taxable year of such taxpayer which includes such month,

“(3) as of the first day of such month, there is in effect for such employee—

“(A) a qualified religious exemption, or

“(B) a qualified disabled veteran exemption,

“(4) as of the first day of such month, such individual is on active duty as a member of the uniformed services (as defined in section 101 of title 10, United States Code),

“(5) the only services performed by such employee for the employer during such month are services the income from which is excluded from gross income for purposes of section 151(c)(1)(A) by reason of section 151(c)(5), or

“(6) the amount of wages paid by the employer to such employee during such month does not exceed \$100.

“(c) DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

“(1) QUALIFIED RELIGIOUS EXEMPTION.—

“(A) IN GENERAL.—The term ‘qualified religious exemption’ means an exemption granted by the Secretary of Health and Human Services to an individual—

“(i) who is a member of a recognized religious sect or division thereof with respect to which such Secretary makes the findings referred to in subparagraphs (C), (D), and (E) of section 1402(g)(1),

“(ii) who is an adherent of established tenets or teachings of such sect or division as described in such section, and

“(iii) who submits an application for such exemption which contains or is accompanied by the evidence described in section 1402(g)(1)(A) and a waiver described in section 1402(g)(1)(B).

For purposes of the clause (iii), section 1402(g)(1)(B) shall be treated as including a reference to medicare part C.

“(B) LIMITATION.—An exemption granted under this paragraph shall cease to apply beginning on the date such Secretary determines that the individual, or the sect or division, ceased to meet the requirements of subparagraph (A).

“(2) QUALIFIED DISABLED VETERAN EXEMPTION.—

“(A) IN GENERAL.—The term ‘qualified disabled veteran exemption’ means an exemption granted by the Secretary of Health and Human Services to an eligible person (within the meaning of section 1710(a)(1) of title 38, United States Code) who waives all benefits and payments under all qualified health plans of any employer and under medicare part C with respect to the guaranteed national benefit package described in title XXI of the Social Security Act.

“(B) MINIMUM PERIOD OF EXEMPTION.—Such an exemption may not be granted for a period of less than 1 year and shall not take effect earlier than the month beginning after the month in which the eligible person requests such waiver.

“(C) TERMINATION BY INDIVIDUAL.—Such an exemption may be terminated by the eligible person. Such a termination shall not take effect earlier than the month beginning after the month in which notice of such termination is sent to the Secretary of Health and Human Services. No subsequent exemption under this paragraph may be granted to such person until 1-year after the date such termination took effect.

“(3) INFLATION ADJUSTMENT OF WAGE AMOUNT.—In the case of months in any calendar year after 1997, the dollar amount contained in subsection (b)(6) shall be increased by an amount equal to—

“(A) such dollar amount, multiplied by

“(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year which includes such month, by substituting ‘calendar year 1994’ for ‘calendar year 1992’ in subparagraph (B) thereof.

If any increase determined under the preceding sentence is not a multiple of \$5, such increase shall be rounded to the nearest multiple of \$5.

“SEC. 3466. QUALIFIED EMPLOYER-COVERED EMPLOYEES.

“(a) IN GENERAL.—For purposes of this chapter, the term ‘qualified employer-covered employee’ means any employee if (and only if)—

“(1) such employee is covered under a qualified health plan of his employer,

“(2) such employee’s coverage under such plan is in accordance with subsection (b),

“(3) such employee was offered such coverage in accordance with subsection (c), and

“(4) the employer makes a contribution for such coverage in accordance with subsection (d).

“(b) COVERAGE REQUIREMENTS.—

“(1) IN GENERAL.—An employee’s coverage under a qualified health plan is in accordance with this subsection if—

“(A) such plan (which may be a high deductible plan, as defined in section 2204(5) of the Social Security Act) was selected by the employee from plans offered consistent with subsection (c),

“(B) family members of the employee are covered under such plan if such family coverage is elected in accordance with such subsection, and

“(C) such coverage does not terminate by reason of termination of employment until the end of the month in which such termination occurs.

“(2) COVERAGE DEFINED.—For purposes of this subsection, an individual is considered to be covered with respect to a plan at such time as the plan bears

a legal responsibility for provision of (or payment for) services for which benefits are included under the plan.

“(c) OFFERING REQUIRED.—

“(1) IN GENERAL.—Coverage is offered in accordance with this subsection with respect to an employee only if the employee is offered coverage under a choice of qualified health plans, including at least—

“(A) 1 managed care plan (as defined in section 2204(7) of the Social Security Act), if available to the employer with respect to the employee, and

“(B) 1 unlimited-choice-of-provider plan (as defined in section 2204(15) of such Act), which may be a point-of-service plan (as defined in section 2204(9) of such Act).

“(2) OFFERING FAMILY COVERAGE.—

“(A) IN GENERAL.—Coverage is offered in accordance with this subsection with respect to an employee only if coverage also is offered for family members under the plan in which the employee obtains coverage.

“(B) FAMILY MEMBERS DEFINED.—For purposes of this section, the term ‘family member’ means, with respect to an employee—

“(i) the employee’s spouse, if the spouse is an eligible individual (as defined in section 1001(c) of the Health Security Act), and

“(ii) any young dependent of the employee, if the dependent is an eligible individual (as so defined).

“(3) TERMS OF OFFERING.—An employer shall not be treated as offering coverage in accordance with this subsection unless the following requirements are met:

“(A) ANNUAL OPEN ENROLLMENT PERIODS.—The employer has an annual open enrollment period of at least 45 days during which employees may change the plan under which they are provided coverage.

“(B) CHANGES IN ENROLLMENT DURING 1ST YEAR OF EMPLOYMENT.—Once during the 1st year of employment with an employer, each employee may change the plan under which the employee is provided coverage. Such a change shall be effective on the first day of the first month beginning at least 45 days after the date the employer receives a notice of change of coverage.

“(C) CHANGES IN FAMILY STATUS.—The offer of family coverage under paragraph (2) is made (in accordance with regulations prescribed by the Secretary) at such times and in such manner as may be necessary to take into account changes in family status and changes in employment of family members.

“(d) REQUIRED CONTRIBUTION.—

“(1) IN GENERAL.—An employer makes a contribution for coverage under a qualified health plan in accordance with this subsection with respect to an employee only if—

“(A) the employer pays the employer contribution amount specified in paragraph (2) for an employee (and family members) covered under a qualified health plan under subsection (b), and

“(B) the portion of the premium for coverage not paid by the employer, net of the value of any premium certificates provided under subpart 1 of part B of title XXIII of the Social Security Act or other premium subsidies provided with respect to the employee, is withheld from wages paid the employee.

“(2) EMPLOYER CONTRIBUTION AMOUNT.—

“(A) FULL-TIME EMPLOYEES.—For purposes of paragraph (1)—

“(i) COVERED UNDER MANAGED CARE PLANS.—In the case of an employee who is covered under a managed care plan (as defined in section 2204(7) of the Social Security Act), the employer contribution amount specified in this paragraph is equal to at least 80 percent of the premium for the qualified managed care plan offered under subsection (c) to the employee that has the lowest premium for the class of enrollment involved (as defined in section 3(b) of the Health Security Act).

“(ii) COVERED UNDER UNLIMITED-CHOICE-OF-PROVIDER PLAN.—In the case of an employee who is covered under an unlimited-choice-of-provider plan (other than a high deductible plan) the employer contribution amount specified in this paragraph is equal to at least 80 percent of the premium for the qualified unlimited-choice-of-provider plan offered under subsection (b) to the employee that has the lowest premium for the class of enrollment involved (as defined in section 3(b) of the Health Security Act) and that is not a high deductible plan.

“(iii) COVERED UNDER HIGH DEDUCTIBLE PLAN.—In the case of an employee who is covered by a qualified health plan that is a high deductible plan, the employer contribution amount specified in this paragraph is the same percent of the premium for such coverage as the percent that would apply under clause (ii) if the employee were covered under an unlimited-choice-of-provider plan that is not a high deductible plan.

“(B) REDUCTION FOR PART-TIME EMPLOYEES.—

“(i) IN GENERAL.—In the case of a part-time employee (as defined in section 3467), the amount specified in this paragraph is an amount that is not less than the applicable fraction (as defined in such section) of the amount otherwise provided under subparagraph (A).

“(ii) EMPLOYER ELECTION TO INCREASE SHARE.—An employer may elect to specify, with respect to any part-time employee for any month, an applicable fraction which is greater than the applicable fraction which would (but for this clause) apply to such employee for such month but not greater than 1. Any fraction so specified shall apply to the employee for the month for which made and all succeeding months beginning before the date it is revoked by the employer.

“(C) CONTRIBUTION TO MEDICAL SAVINGS ACCOUNT REQUIRED IF COVERAGE UNDER HIGH DEDUCTIBLE MEDICAL SAVINGS ACCOUNT PLAN.—

“(i) IN GENERAL.—An employer shall not be treated as making a contribution for coverage under a qualified health plan in accordance with this subsection in the case of an employee covered under a high deductible plan, unless the employer also makes a contribution in the amount of the medical savings contribution amount specified in clause (ii) into a medical savings account (as defined in section 7705(a)) on behalf of the employee. Such a contribution shall be made not later than the date of the premium payment to which it relates.

“(ii) MSA CONTRIBUTION AMOUNT.—For purposes of clause (i), the term ‘medical savings contribution amount’ means, for an employee covered under a high deductible plan, an amount equal to the excess of—

“(I) the employer contribution amount that would apply under this paragraph if the employee were covered under an unlimited-choice-of-provider plan that was not a high deductible plan, over

“(II) the employer contribution amount made for coverage under the high deductible plan.

“(D) HIGH DEDUCTIBLE PLAN.—For purposes of this paragraph, the term ‘high deductible plan’ has the meaning given such term by section 2204(5) of the Social Security Act.

“(3) DETERMINATION OF PREMIUM.—

“(A) IN GENERAL.—For purposes of this subsection, the term ‘premium’ means, with respect to—

“(i) a qualified health plan that is offered by a carrier (as defined in section 2204(2) of the Social Security Act), the premium established by the carrier for the plan with respect to the guaranteed national benefit package described in title XXI of such Act; or

“(ii) any other qualified health plan, a reasonable estimate of the aggregate accident and health coverage expenditures of the plan (as determined under section 4376(d)) for the period involved with respect to such guaranteed national benefit package which—

“(I) is determined on an actuarial basis for different classes of enrollment (consistent with part C of title XXII of the Social Security Act), and

“(II) takes into account such factors as the Secretary, in consultation with the Secretary of Health and Human Services, may prescribe.

“(B) PREMIUM BASED ON CLASS OF ENROLLMENT.—The premium with respect to an employee for a month shall be based on the class of enrollment (as defined in section 3(b) of the Health Security Act) with respect to which the employee is provided coverage as of the first day of the month.

“(C) ADDITIONAL RULES.—Rules similar to the rules in clauses (ii) and (iii) of subparagraph (B), and subparagraph (C), of section 4980B(f)(4) shall apply to the determination of the premium, except that the adjustment under subparagraph (B)(ii)(II) of such section shall be by the sum described in section 6001(c) of the Health Security Act).

"(4) COMPLIANCE WITH PREMIUM CERTIFICATE REQUIREMENTS.—An employer is not considered to have made a contribution for coverage with respect to an employee in accordance with this subsection unless—

"(A) the employer provides the employee, upon request, with such documentation, in such form and in such a timely manner, as the Secretary of Health and Human Services specifies, as the employee may require to apply for and obtain a premium certificate under subpart 1 of part A of title XXIII of the Social Security Act; and

"(B) if the employee tenders to the employer a premium certificate issued under such subpart, the employer reduces by the value of the certificate the amount of any premium required to be paid by the employee for periods beginning after the date of tender of the certificate unless otherwise provided.

"SEC. 3467. DEFINITIONS AND SPECIAL RULES.

"(a) QUALIFIED HEALTH PLAN; MEDICARE PART A.—For purposes of this chapter, the terms 'qualified health plan' and 'medicare part A' have the meanings given to such terms by paragraphs (2) and (3) of section 59B(d).

"(b) FULL-TIME EMPLOYEE; PART-TIME EMPLOYEE; APPLICABLE FRACTION.—For purposes of this chapter—

"(1) FULL-TIME EMPLOYEE.—The term 'full-time employee' means any employee of an employer whose normal work week for such employer is not less than 35 hours.

"(2) PART-TIME EMPLOYEE.—The term 'part-time employee' means any employee who is not a full-time employee.

"(3) APPLICABLE FRACTION.—The applicable fraction is a fraction—

"(A) the numerator of which is the number of hours in the employee's normal work week, and

"(B) the denominator of which is 35.

"(4) TREATMENT OF EMPLOYEES WHOSE FULL-TIME NORMAL WORK WEEK IS LESS THAN 35 HOURS.—Under regulations prescribed by the Secretary—

"(A) IN GENERAL.—An employee shall be treated as a full-time employee if such employee is employed by the employer on a continuing basis that, taking into account the structure or nature of the employment in the industry in which such employee is employed, represents full-time employment.

"(B) PART-TIME EMPLOYEES.—With respect to an industry in which an employee is treated as a full-time employee solely by reason of subparagraph (A), the applicable fraction of an employee employed in such industry who is not so treated shall be the fraction which such employee's normal work week bears to full-time employment (as determined under subparagraph (A)).

"(C) EXCEPTION.—Subparagraphs (A) and (B) and subsection (c) shall not apply for purposes of section 3462.

"(5) AGGREGATION RULES.—For purposes of this subsection—

"(A) all employers treated as a single employer under subsection (a) or (b) of section 52 shall be treated as a single employer, and

"(B) all employees of the members of an affiliated service group (as defined in section 414(m)) shall be treated as employed by a single employer.

"(c) TREATMENT OF EMPLOYEES OF EDUCATIONAL ORGANIZATIONS.—For purposes of this chapter—

"(1) IN GENERAL.—Notwithstanding subsection (b)(4), an employee of an educational organization shall be treated as a full-time employee if such employee's normal work week is the customary hours that constitute full-time employment for such organization (as determined by such organization).

"(2) PART-TIME EMPLOYEES.—The applicable fraction of an employee of an educational organization who is not treated as a full-time employee under paragraph (1) shall be the fraction which such employee's normal work week bears to the customary hours that constitute full-time employment for such organization (as so determined).

"(3) SUMMER MONTHS, ETC.—In the case of a period between 2 successive academic years or terms, if—

"(A) an employee of an educational organization performs services in the first of such academic years or terms,

"(B) such employee performs substantially reduced services (if any) during such period, and

"(C) there is a reasonable assurance that such employee will perform such services in the second of such academic years or terms,

then the employee shall be treated as an employee of such organization during such period and as having the same normal work week (and compensation) as such employee had in the first of such years or terms.

"(4) EMPLOYEE OF EDUCATIONAL ORGANIZATION DEFINED.—For purposes of this subsection, an individual is an employee of an educational organization if such individual—

"(A) is an employee of an institution of higher education (as defined in section 1201(a) of the Higher Education Act of 1965) or an elementary or secondary school (as defined in section 1471 of the Elementary and Secondary Education Act of 1965), and

"(B) is employed in a capacity described in so much of section 13(a)(1) of the Fair Labor Standards Act as ends with 'secondary schools'.

"(d) NO COVER OVER TO POSSESSIONS.—Notwithstanding any other provision of law, no amount collected under this chapter shall be covered over to any possession of the United States.

"(e) OTHER DEFINITIONS.—For purposes of this chapter, the terms 'State', 'wages', 'employer', 'employment', and 'employee' have the same respective meanings as when used in chapter 21: except that, for purposes of this chapter, the following provisions of chapter 21 shall not apply:

"(1) Paragraph (1) of section 3121(a).

"(2) Paragraph (5) of section 3121(b).

"(3) Paragraph (7) of section 3121(b) (other than subparagraph (C) or (F) thereof).

"(4) Paragraph (9) of section 3121(b).

"(f) MEDICARE PART C.—For purposes of this chapter, the term "medicare part C" means the program of health insurance benefits under part A of title XXIII of the Social Security Act.

"(g) REGULATIONS.—The Secretary may prescribe such regulations as may be appropriate to carry out the purposes of this chapter, including regulations prescribing 1 or more simplified methods (including brackets of hours) for determining the applicable fraction and full-time equivalent employees."

(b) MODIFICATION OF WITHHOLDING EXEMPTION CERTIFICATE REQUIREMENTS.—Subsection (f) of section 3402 is amended by adding at the end the following new paragraph:

"(8) CERTIFICATE TO INCLUDE INFORMATION RELATED TO MEDICARE PART C STATUS.—

"(A) INITIAL CERTIFICATE.—On the withholding exemption certificate furnished by an employee under paragraph (2)(A), the employee shall certify—

"(i) whether the employee—

"(I) is covered under medicare part A or a qualified health plan (as defined in section 59B(d)) other than a plan of such employer, or

"(II) reasonably expects to be a young dependent (as defined in section 59B(e)(5)) of any taxpayer,

"(ii) whether the employee has a young dependent (as so defined),

"(iii) the State (or place outside the United States) in which such employee has his principal place of abode, and

"(iv) such other information as the Secretary may require.

"(B) CHANGE OF STATUS.—If, on any day, there is a change in any item of information required to be certified under subparagraph (A) on the withholding exemption certificate then in effect with respect to an employee, such employee shall within 10 days thereafter furnish the employer with a new withholding exemption certificate containing the information described in subparagraph (A)."

(c) MODIFICATION OF PENALTY FOR FAILURE TO MAKE DEPOSIT OF TAXES.—Section 6656 (relating to failure to make deposit of taxes) is amended by adding at the end the following new subsection:

"(c) REDUCTIONS IN DEPOSITS BY REASON OF HEALTH-RELATED CREDITS.—No penalty shall be imposed by subsection (a) on any underpayment attributable to the depositor's estimate of any deemed payment under subchapter B of chapter 25 (relating to health-related employer credits) unless there is no reasonable basis for such estimate."

(d) CLERICAL AMENDMENT.—The table of chapters for subtitle C is amended by striking the item relating to chapter 25 and inserting the following:

"Chapter 25. Health-related employer taxes and credits.

"Chapter 26. General provisions relating to employment taxes."

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall take effect on January 1, 1998.

(2) APPLICATION OF SECTION 3451 TO LARGER EMPLOYERS.—Section 3451 of the Internal Revenue Code of 1986 (as added by this section) shall take effect on January 1, 1996.

SEC. 2202. REPORTING REQUIREMENTS.

(a) EMPLOYER SHARE OF MEDICARE PART C PREMIUM SHOWN ON W-2.—Subsection (a) of section 6051 (relating to receipts for employees) is amended by striking “and” at the end of paragraph (8), by striking the period at the end of paragraph (9) and inserting a comma, and by inserting after paragraph (9) the following new paragraphs:

“(10) the total mandatory employer taxes (as defined in section 59B(e)(3)) with respect to such employee, and

“(11) the total elective employer taxes (as defined in section 59B(e)(4)) with respect to such employee.”

(b) RETURNS RELATING TO QUALIFIED HEALTH PLANS AND MEDICARE PART A, DIRECT PREMIUM PAYMENTS TO HHS, AND MEDICARE PART C COVERAGE OF EMPLOYEES.—Subpart B of part III of subchapter A of chapter 61 (relating to information concerning transactions with others) is amended by adding at the end the following new sections:

“SEC. 6050Q. RETURNS RELATING TO QUALIFIED HEALTH PLANS AND MEDICARE PART A.

“(a) REQUIREMENT OF REPORTING.—The administrator of any qualified health plan (as defined in section 59B(d)) and the Secretary of Health and Human Services with respect to medicare part A (as defined in such section) shall make a return for each calendar year setting forth—

“(1) the name and TIN of each individual covered under such plan or program at any time during such taxable year as a primary insured or as the spouse of a primary insured,

“(2) the name and TIN (to the extent available) of each individual covered under such plan or program at any time during such taxable year as a young dependent (as defined in section 59B(e)(5)) of a primary insured, and

“(3) the months during such calendar year for which such individuals were so covered.

Such return shall be made at such time and in such form as the Secretary may by regulations prescribe.

“(b) STATEMENTS TO PRIMARY INSURED INDIVIDUALS.—Every administrator (and the Secretary of Health and Human Services) required to make a return under subsection (a) shall furnish to each individual whose name is required to be set forth in such return by reason of being a primary insured a written statement showing—

“(1) the name of the qualified health plan (or medicare part A) and the address of its administrator (or of the Secretary), and

“(2) the information required to be shown on the return with respect to such primary insured.

The written statement required under the preceding sentence shall be furnished to the person on or before January 31 of the year following the calendar year for which the return under subsection (a) was required to be made.

“(c) STATEMENT TO SPOUSE OR YOUNG DEPENDENTS OF PRIMARY INSURED ON REQUEST.—At the request of an individual who, at any time during a calendar year, was the spouse or a young dependent (as defined in section 59B(e)(5)) of a primary insured who is required to receive a statement under subsection (b) from an administrator, such administrator shall furnish to such individual a copy of such statement with respect to such insured for such calendar year.

“SEC. 6050R. RETURNS RELATING TO MEDICARE PART C PREMIUM PAYMENTS TO DEPARTMENT OF HEALTH AND HUMAN SERVICES.

“(a) REQUIREMENT OF REPORTING.—The Secretary of Health and Human Services shall make a return for each calendar year setting forth—

“(1) the name and TIN of each individual from whom such Secretary received payments during such year under section 2323(b) of the Social Security Act for coverage under medicare part C (as defined in section 3467), and

“(2) the amount of such payments during such year.

Such return shall be made at such time and in such form as the Secretary may by regulations prescribe.

“(b) STATEMENTS TO INDIVIDUALS.—The Secretary of Health and Human Services shall furnish to each individual whose name is required to be set forth in such return a written statement showing the aggregate payments described in subsection (a) received by such Secretary from such individual. The written statement required

under the preceding sentence shall be furnished to the person on or before January 31 of the year following the calendar year for which the return under subsection (a) was required to be made.

"SEC. 6050S. RETURNS RELATING TO EMPLOYER MEDICARE PART C PREMIUM PAYMENTS.

"Every employer who pays tax under section 3455 (relating to employer share of medicare part C premiums) with respect to the employment of any employee during any calendar year shall make a return for such year setting forth—

"(1) the name and TIN of each such employee,

"(2) the class of enrollment on which such tax was determined with respect to each such employee for each month of such year,

"(3) the name and TIN of the spouse of such employee,

"(4) the name and TIN (to the extent available) of each young dependent (as defined in section 59B(e)(5)) of such employee.

Such return shall be made at such time and in such form as the Secretary may by regulations prescribe."

(c) MONTHLY STATEMENTS TO EMPLOYEES TO SPECIFY EMPLOYER SHARE OF MEDICARE PART C PREMIUM.—Section 6051 (relating to receipts for employees) is amended by adding at the end the following new subsection:

"(g) EMPLOYER SHARE OF MEDICARE PART C PREMIUM.—Every employer required to pay a tax under section 3455 with respect to any employee for any month shall furnish to each such employee a written statement showing the aggregate amount of such tax paid by such employer with respect to such employee for such month. Such statement shall be furnished with the employer's payment of wages for the payroll period which includes the last day of such month or at such times as may be specified by the Secretary by regulations."

(d) UNIFORM PENALTY PROVISIONS MADE APPLICABLE.—

(1) Subparagraph (B) of section 6724(d)(1) is amended by inserting after the item relating to clause (viii) the following new items (and redesignating the following clauses accordingly):

"(ix) section 6050Q(a) (relating to returns regarding qualified health plans and medicare part A),

"(x) section 6050R(a) (relating to returns relating to medicare part C premium payments to Department of Health and Human Services),

"(xi) section 6050S (relating to returns relating to employer medicare part C premium payments)."

(2) Paragraph (2) of section 6724(d) is amended by inserting after subparagraph (P) the following new subparagraph (and by redesignating the following subparagraphs accordingly):

"(Q) subsection (b) or (c) of section 6050Q (relating to returns regarding qualified health plans and medicare part A),

"(R) section 6050R(b) (relating to returns relating to medicare part C premium payments to Department of Health and Human Services)."

(e) DISCLOSURE OF INFORMATION BY SECRETARY.—

(1) Subsection (l) of section 6103 is amended by adding at the end the following new paragraphs:

"(15) DISCLOSURE OF RETURN INFORMATION TO CARRY OUT HEALTH PREMIUM CERTIFICATE PROGRAM.—The Secretary shall, upon written request from the Secretary of Health and Human Services, disclose to officers and employees of the Department of Health and Human Services return information for purposes of determining or verifying whether any taxpayer is entitled to a premium certificate under subpart 1 of part A of title XXIII of the Social Security Act and the amount thereof. Such return information shall be limited to—

"(A) such taxpayer's marital status,

"(B) the adjusted gross income of such taxpayer,

"(C) the interest received by such taxpayer which is exempt from tax, and

"(D) the number of personal exemptions of such taxpayer.

Return information disclosed under this paragraph may be used by such officers and employees only for the purposes of, and to the extent necessary in, making such determination or verification.

"(16) DISCLOSURE OF RETURN INFORMATION RELATING TO SUBSIDIES TO STATES ADOPTING STATE BENEFIT MANAGEMENT PROGRAMS.—The Secretary shall, upon written request from the Secretary of Health and Human Services, disclose to officers and employees of the Department of Health and Human Services return information necessary to determine or verify the proper amount payable under section 2324(c)(1)(C) of the Social Security Act to a State which has a State benefit management program approved under subtitle B of title IV of the Health Security Act. Return information disclosed under this paragraph may be used

by such officers and employees only for the purposes of, and to the extent necessary in, making such determination or verification."

(2) Paragraph (4) of section 6103(p) is amended by striking "or (14)" each place it appears and inserting "(14), (15), or (16)".

(f) CLERICAL AMENDMENT.—The table of sections for subpart B of part III of subchapter A of chapter 61 is amended by adding at the end the following new items:

"Sec. 6050Q. Returns relating to qualified health plans and medicare part A.

"Sec. 6050R. Returns relating to medicare part C premium payments to Department of Health and Human Services.

"Sec. 6050S. Returns relating to employer medicare part C premium payments."

(g) EFFECTIVE DATE.—The amendments made by this section (other than subsection (e)) shall apply to calendar years after 1997.

SEC. 2203. TRANSITIONAL CONTINUATION COVERAGE REQUIREMENT FOR GROUP HEALTH PLANS.

Clause (i) of section 4980B(f)(2)(B) is amended by adding at the end the following new sentence: "In the case of an individual whose period of coverage under this clause would (but for this sentence) end after the date of the enactment of the Health Security Act and before January 1, 1998, such period shall in no event terminate by reason of this clause before January 1, 1998."

SEC. 2204. TAXES ON EMPLOYERS FAILING TO MEET CERTAIN OTHER HEALTH COVERAGE-RELATED REQUIREMENTS.

(a) IN GENERAL.—Chapter 43 is amended by adding at the end the following new section:

"SEC. 4980C. FAILURE TO SATISFY CERTAIN OTHER HEALTH COVERAGE-RELATED REQUIREMENTS.

"(a) GENERAL RULE.—There is hereby imposed a tax on the failure of any employer to meet any of the following requirements with respect to any individual if the employer is required to meet such requirements with respect to such individual:

"(1) The requirements of subsection (e) (relating to maintenance-of-effort in providing health benefits to employees).

"(2) The requirements of subsection (f) (relating to nondiscrimination requirements in providing excess health benefits to full-time employees).

"(3) The requirements of subsection (g) (relating to maintenance-of-effort requirements with respect to former employees).

"(b) AMOUNT OF TAX.—

"(1) IN GENERAL.—The amount of the tax imposed by subsection (a) on any failure with respect to an individual shall be \$100 for each day in the non-compliance period with respect to such failure.

"(2) NONCOMPLIANCE PERIOD.—For purposes of this section, the term 'non-compliance period' means, with respect to any failure, the period comparable to the noncompliance period under section 4980B with respect to failures under such section.

"(3) MINIMUM TAX FOR NONCOMPLIANCE PERIOD WHERE FAILURE DISCOVERED AFTER NOTICE OF EXAMINATION.—A rule similar to the rule of section 4980B(b)(3) shall apply for purposes of this subsection.

"(c) LIMITATIONS ON AMOUNT OF TAX.—Rules similar to the rules of section 4980B(c) shall apply for purposes of this section.

"(d) LIABILITY FOR TAX.—The liability for the tax imposed by this section on any failure shall be determined under the rules of section 4980B(e) (other than paragraph (2)(B) thereof).

"(e) MAINTENANCE-OF-EFFORT IN PROVIDING HEALTH BENEFITS TO EMPLOYEES.—

"(1) EMPLOYERS TO WHICH SUBSECTION APPLIES.—This subsection shall apply to any employer if such employer (or any predecessor) offered as of January 1, 1994, health benefits to any employee.

"(2) REQUIREMENTS.—An employer meets the requirements of this subsection only if the employer offers, throughout the 5-year period beginning on the date of the enactment of the Health Security Act, at least the level of health benefits offered as of January 1, 1994, to—

"(A) the employees, spouses, and dependents to whom such benefits were offered as of such date, and

"(B) similarly situated employees, spouses, and dependents.

"(3) COLLECTIVE BARGAINING AGREEMENTS.—To the extent health benefits are provided pursuant to a collective bargaining agreement between employee representatives and 1 or more employers which was ratified before the date of the enactment of the Health Security Act, the 5-year period referred to in paragraph (2) shall not expire before the date on which such agreement terminates

(determined without regard to any extension thereof on or after the date of the enactment of the Health Security Act). The preceding sentence shall cease to apply with respect to any such agreement on the effective date of any modification of such agreement on or after June 29, 1994.

"(4) EFFECTIVE DATE.—The requirements of this subsection shall apply to benefits offered on or after the date of the enactment of the Health Security Act.

"(f) NONDISCRIMINATION REQUIREMENTS IN PROVIDING ADDITIONAL HEALTH BENEFITS TO FULL-TIME EMPLOYEES.—

"(1) EMPLOYERS TO WHICH SUBSECTION APPLIES.—This subsection shall apply to any employer who makes an additional health benefit payment on behalf of any full-time employee.

"(2) REQUIREMENTS.—An employer meets the requirements of this subsection only if all full-time employees are offered the same amount of additional health benefit payments. The requirements of this paragraph shall be applied separately with respect to employees enrolled in different classes of enrollment.

"(3) SAFE HARBOR RULES RELATING TO PREMIUM PAYMENTS.—In any case in which an additional health benefit payment is an additional premium payment for a qualified health plan (as defined in section 59B(d)(2)), the employer shall not be treated as failing to meet the requirements of this subsection if such payment meets the requirements of any (or any combination) of the following subparagraphs:

"(A) LEVEL PERCENTAGE CONTRIBUTION FOR PLAN SELECTED.—The additional payment amount is a fixed percentage of the premium under each qualified health plan offered. Such percentage may vary based on class of enrollment (as defined in section 3(b) of the Health Security Act).

"(B) LEVEL PERCENTAGE CONTRIBUTION FOR CATEGORY OF PLAN.—The additional payment amount is a fixed percentage of the premium for the lowest cost plan within each category of qualified health plans offered. Such percentage may vary based on class of enrollment (as so defined).

"(C) EQUALIZING DOLLAR AMOUNTS OF REQUIRED CONTRIBUTIONS.—The additional payment amount is the minimum dollar amount, within such a class of enrollment, that is required to assure that the total dollar contribution by the employer (including both the minimum required contribution and the additional payment amount) for all employees is equal to the greater of—

"(i) the minimum level of employer contribution required for a managed care plan, or

"(ii) the minimum level of employer contribution required for an unlimited-choice-of-provider plan, without regard to the plan selected. Such dollar amount may vary based on class of enrollment.

"(D) LEVEL DOLLAR AMOUNTS OF ADDITIONAL CONTRIBUTIONS.—The payment is a fixed equal dollar amount per full-time employee, without regard to the plan selected. Such premium contribution may vary, or not vary, based on such a class of enrollment.

For purposes of applying this paragraph, the term 'premium' includes, with respect to a high deductible medical savings plan, a contribution to a medical savings account.

"(4) DIFFERENT TREATMENT OF UNLIMITED-CHOICE-OF-PROVIDER PLANS AND MANAGED CARE PLANS.—If any additional benefit consists of a reduction in the cost sharing otherwise required under the guaranteed national benefit package described in title XXI of the Social Security Act—

"(A) such reduction shall be treated as an additional health benefit payment, and

"(B) the requirements of this subsection shall be met only if any difference in such reduction between unlimited-choice-of-provider plans and managed care plans meets such terms and conditions as may be prescribed by the Secretary by regulations.

"(5) DEFINITIONS.—For purposes of this subsection—

"(A) ADDITIONAL HEALTH BENEFIT PAYMENT.—The term 'additional health benefit payment' means any payment designed to be used exclusively (or primarily) towards the cost of health insurance coverage and does not include any tax imposed by chapter 25.

"(B) EXCESS HEALTH BENEFIT.—The term 'excess health benefit' has the meaning given such term by subsection (e).

"(C) FULL-TIME EMPLOYEE.—The term 'full-time employee' means any full-time employee (as defined in section 3467) with respect to whom the employer is required to make a contribution under section 3466(d).

“(6) AGGREGATION RULES.—For purposes of this subsection—

“(A) all employers treated as a single employer under subsection (a) or (b) of section 52 shall be treated as a single employer, and

“(B) all employees of the members of an affiliated service group (as defined in section 414(m)) shall be treated as employed by a single employer.

“(7) EXCEPTION FOR COLLECTIVE BARGAINING AGREEMENT.—This subsection shall not apply with respect to additional health benefits provided pursuant to a bona fide collective bargaining agreement or to a multiemployer plan.

“(8) EFFECTIVE DATE.—

“(A) IN GENERAL.—This subsection shall apply to benefits provided—

“(i) by a large employer (as defined in section 3451(d)) on or after January 1, 1996, or

“(ii) by another employer on or after January 1, 1998.

“(B) RELATIONSHIP TO TRANSITIONAL MAINTENANCE-OF-EFFORT REQUIREMENTS.—An employer shall not be considered to have failed to comply with the requirements of this subsection because of the provision of additional health benefit payments that are required to be provided pursuant to subsection (e).

“(g) MAINTENANCE-OF-EFFORT REQUIREMENTS WITH RESPECT TO FORMER EMPLOYEES.—

“(1) EMPLOYERS TO WHICH SUBSECTION APPLIES.—This subsection shall apply to any employer if such employer (or any predecessor), as of October 1, 1993, was paying any portion of the health costs for a qualified retiree or a qualified spouse or child.

“(2) REQUIREMENTS.—

“(A) IN GENERAL.—An employer meets the requirements of this subsection only if—

“(i) each individual who is a qualified retiree or a qualified spouse or child is offered coverage under each qualified health plan of such employer that is offered to any full-time employee of the employer, and

“(ii) with respect to such individuals who elect coverage under a qualified health plan of such employer, the employer contribution for each month is an amount equal to 80 percent of the cost of providing such coverage.

“(B) OPTION TO PROVIDE EMPLOYER CONTRIBUTION TO MEDICARE PART C.—For periods beginning on or after January 1, 1998, an employer also shall meet the requirements of this subsection if—

“(i) each individual who is a qualified retiree or a qualified spouse or child is offered coverage under medicare part C (as defined in section 3467), and

“(ii) the employer contribution for each month for each such individual who elects coverage (or is covered) under the medicare part C is an amount equal to the employer's share of applicable medicare part C premium for such month (as determined under section 3455).

“(3) QUALIFIED RETIREE DEFINED.—For purposes of this subsection, the term ‘qualified retiree’ means an eligible individual who—

“(A) has attained age 55 but not age 65,

“(B) is not a full-time employee, and

“(C) is not a medicare part A beneficiary.

“(4) QUALIFIED SPOUSE OR CHILD DEFINED.—For purposes of this subsection, the term ‘qualified spouse or child’ means, in relation to a qualified retiree, an eligible individual with respect to whom the requirements in one of the following subparagraphs is met:

“(A) The individual (i) is under 65 years of age and is (and has been for a period of at least one year) married to a qualified retiree or (ii) is a child of the qualified retiree.

“(B) In the case of a person who was a qualified retiree at the time of the person's death—

“(i) the individual was (and had for a period of at least one year been) married to the retiree at the time of the person's death,

“(ii) the individual is under 65 years of age,

“(iii) the individual is not a full-time employee,

“(iv) the individual is not remarried, and

“(v) the deceased spouse would still be a qualified retiree if such spouse had not died.

“(C) The individual is a child of an individual described in subparagraph (B).

“(5) EMPLOYER.—For purposes of this subsection, the term ‘employer’ includes, with respect to any qualified retiree under a State or local retirement system (or the qualified spouse or child of such a retiree), such system.

“(6) EFFECTIVE DATE.—This subsection shall apply to coverage for periods beginning on or after the date of the enactment of the Health Security Act.”

(b) CLERICAL AMENDMENT.—The table of sections for chapter 43 is amended by adding at the end the following new item:

“Sec. 4980C. Failure to satisfy certain other health coverage-related requirements.”

TITLE III—BENEFITS

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SEC. 3000. REFERENCES IN TITLE.

(a) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this title an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(b) REFERENCES TO OBRA.—In this title, the terms “OBRA-1986”, “OBRA-1987”, “OBRA-1989”, “OBRA-1990”, and “OBRA-1993” refer to the Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509), the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203), the Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239), the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508), and the Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66), respectively.

Subtitle A—Guaranteed National Benefit Package

SEC. 3001. ESTABLISHMENT OF PACKAGE.

The Social Security Act is amended by adding at the end the following new title:

“TITLE XXI—GUARANTEED NATIONAL BENEFIT PACKAGE

“PART A—BENEFITS DESCRIBED

“SEC. 2101. COVERAGE OF EXPANDED MEDICARE BENEFITS.

“(a) IN GENERAL.—Except as otherwise provided in section 2102, section 2103, and part B, for purposes of this Act and the Health Security Act, the guaranteed national benefit package shall consist of the same items and services for which payment may be made under title XVIII (as amended by the Health Security Act) to individuals entitled to benefits under part A, and enrolled under part B, of title XVIII, subject to the same exclusions from coverage as are provided under section 1862(a).

“(b) ENHANCED MEDICARE BENEFITS DESCRIBED.—In addition to the items and services covered under title XVIII as of the date of the enactment of this title, the guaranteed national benefit package shall include the following items and services for which coverage is provided under title XVIII as a result of the amendments to such title made by the Health Security Act:

“(1) Outpatient prescription drugs (as added by section 3101 of the Health Security Act).

“(2) Limitations on out-of-pocket expenditures (as added by section 3111 of such Act).

“(3) Unlimited days of coverage for inpatient hospital services (as added by section 3112 of such Act).

“(4) Newborn, well-baby, and well-child services and hearing aids (as added by section 3113 of such Act).

“(5) Expanded coverage of screening mammography (provided under section 3114(a) of such Act) and screening pap smears (provided under section 3114(b) of such Act).

“(6) Screening fecal-occult blood tests, screening flexible sigmoidoscopies, and screening colonoscopy (as added by section 3114(c) of such Act).

“(7) Screening for sexually-transmitted diseases (as added by section 3114(d) of such Act).

“(8) Pregnancy-related services and family planning (as added by section 3115 of such Act).

“(9) Expanded coverage for mental health and substance abuse services (as provided under section 3116 of such Act).

“(10) Expanded coverage for certain chiropractic services (as provided under section 3117 of such Act).

“SEC. 2102. COVERAGE OF ITEMS AND SERVICES NOT COVERED UNDER MEDICARE.

“(a) SERVICES INCIDENT TO INVESTIGATIONAL TREATMENTS.—

“(1) IN GENERAL.—The guaranteed national benefit package shall include coverage of any item or service provided to an individual incident to a qualifying investigational treatment conducted to determine the medical necessity or appropriateness of the item or service if the item or service is included in the guaranteed national benefit package.

“(2) QUALIFYING INVESTIGATIONAL TREATMENT DEFINED.—In this subsection, a ‘qualifying investigational treatment’ means an investigational treatment provided under a clinical research trial approved by the Secretary or a qualified non-governmental research entity (as defined in guidelines of the National Institutes of Health, including guidelines for designated cancer support grants of the National Cancer Institute), or a peer-reviewed and approved research program (as defined by the Secretary), conducted for the primary purpose of determining whether or not a treatment is safe, efficacious, or having any other characteristic of a treatment which must be demonstrated in order for the treatment to be medically necessary or appropriate.

“(3) EXCLUSIONS.—Nothing in this subsection may be construed to provide for coverage under the guaranteed national benefit package of an item or service of a class or type for which the Secretary determines that payment is generally made from sources other than qualified health plans, including the investigational agent or device itself or the investigational procedure, any non-health services that might be required for a person to receive the qualifying investigational treatment, or the costs of managing the research.

“(b) MODIFICATION OF COVERAGE FOR SCREENING SERVICES.—In consultation with appropriate experts in the area of preventive medicine (including the Advisory Council on Immunological Practices of the Centers for Disease Control and Prevention), the Secretary may modify the coverage of immunizations and other preventive services otherwise provided under the guaranteed national benefit package under this part to provide for coverage of additional services or to increase the frequency of coverage, but only if any such modification is determined to be clinically appropriate and to not result in any increase in the premium imposed under the health insurance program established under part A of title XXIII.

“SEC. 2103. MODIFICATION OF MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS UNDER APPROVED MANAGED MENTAL HEALTH PROGRAMS.

“(a) SUBSTITUTION OF MENTAL HEALTH BENEFITS PROVIDED UNDER PROGRAM FOR BENEFITS PROVIDED UNDER GUARANTEED NATIONAL BENEFIT PACKAGE.—In the case of an individual who is a resident of a State operating a comprehensive managed mental health program approved by the Secretary under section 4201 of the Health Security Act for a month, the individual is considered to have waived the right to benefits for mental health services under the guaranteed national benefit package

under this title in consideration of receipt of benefits for mental health services through such program.

“(b) MENTAL HEALTH SERVICES DESCRIBED.—In this section, the term ‘mental health services’ means the following items and services:

“(1) Inpatient psychiatric services (as described in section 1812(a)(5).

“(2) Any items or services furnished under part B for the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital.

“(3) Intensive community-based mental health services (as described in section 1861(ff)).

“(4) Intensive residential services (as described in section 1861(qq)).

“PART B—COST-SHARING

“SEC. 2111. APPLICATION OF COST-SHARING SCHEDULES.

“(a) IN GENERAL.—Benefits provided under the guaranteed national benefit package shall be subject to one of the following cost-sharing schedules offered by a qualified health plan and medicare part C:

“(1) The standard cost-sharing schedule described in section 2113.

“(2) The managed care cost-sharing schedule described in section 2114.

“(b) TREATMENT OF DEDUCTIBLES.—

“(1) APPLICATION ON AN ANNUAL BASIS.—The deductibles for a year under the schedules referred to in subsection (a) shall be applied based upon expenses incurred for items and services covered under the guaranteed national benefit package that are furnished in the year.

“(2) INDIVIDUAL AND FAMILY GENERAL DEDUCTIBLES.—

“(A) INDIVIDUAL.—Subject to subparagraphs (B) and (C), with respect to an individual enrolled under a qualified health plan or medicare part C (regardless of the class of enrollment), any individual general deductible in the cost sharing schedule offered by the plan represents the amount of countable expenses (as defined in subparagraph (D)) that the individual may be required to incur in a year before the plan incurs liability for expenses for items and services covered under the guaranteed national benefit package that are furnished to the individual.

“(B) FAMILY.—Subject to subparagraph (C), in the case of an individual enrolled under a qualified health plan or medicare part C other than under an individual class of enrollment (as defined in section 3(b) of the Health Security Act), the individual general deductible under subparagraph (A) shall not apply to countable expenses incurred by any member of the individual’s family in a year at such time as the family members included in such enrollment have incurred, in the aggregate, countable expenses in the amount of the family general deductible for the year.

“(C) SPECIAL RULE FOR HIGH DEDUCTIBLE PLANS.—In the case of an individual enrolled under a qualified health plan that is a high deductible plan (as defined in section 2204(5)) in a class of enrollment other than an individual class of enrollment, subparagraph (A) shall not apply and the family general deductible represents the amount of countable expenses (as defined in subparagraph (D)) that the members of family may be required to incur in the aggregate in a year before the plan incurs liability for expenses for items and services covered under the guaranteed national benefit package that are furnished to such members.

“(D) COUNTABLE EXPENSE.—In this paragraph, the term ‘countable expense’ means, with respect to an individual for a year, an expense for an item or service covered under the guaranteed national benefit package that is subject to the general deductible and for which, but for such deductible and any other cost sharing under this part, a health plan is liable for payment. The amount of countable expenses for an individual for a year under this paragraph shall not exceed the individual general deductible for the year.

“(c) TREATMENT OF COINSURANCE AND COPAYMENTS.—After a general or separate deductible that applies to an item or service covered under the guaranteed national benefit package has been satisfied for a year, coinsurance and copayments are amounts (expressed as a percentage of an amount otherwise payable or as a dollar amount, respectively) that an individual may be required to pay with respect to the item or service.

“(d) ROUNDING OF AMOUNTS.—Any amount expressed in dollars in this part shall be rounded to the nearest multiple of \$1.

"SEC. 2112. LIMITS ON OUT-OF-POCKET EXPENDITURES.

"(a) ANNUAL OUT-OF-POCKET LIMIT ON COST-SHARING FOR SERVICES OTHER THAN OUTPATIENT PRESCRIPTION DRUGS.—The total amount of cost-sharing incurred in a year (beginning with 2003) with respect to items and services covered under the guaranteed national benefit package (other than outpatient prescription drugs) may not exceed the following:

"(1) In the case of an individual enrolled under a qualified health plan or medicare part C under an individual class of enrollment (as defined in section 3(b) of the Health Security Act)—

"(A) for 2003, an amount equal to \$5,500, increased by the average annual percentage increase in the per capita gross domestic product (in current dollars, as published by the Secretary of Commerce) during the 5-year period ending with 1998 and by the national medicare growth factors established for each of the years 1999 through 2003 under section 8201(c) of the Health Security Act; and

"(B) for each succeeding year, the amount determined under this paragraph for the previous year, increased by the national medicare growth factor established for the year under section 8201(c) of the Health Security Act.

"(2) In the case of an individual enrolled under a qualified health plan or medicare part C under any other class of enrollment—

"(A) for 2003, an amount equal to \$11,000, increased by the average annual percentage increase in the per capita gross domestic product (in current dollars, as published by the Secretary of Commerce) during the 5-year period ending with 1998 and by the national medicare growth factors established for each of the years 1999 through 2003 under section 8201(c) of the Health Security Act; and

"(B) for each succeeding year, the amount determined under this paragraph for the previous year, increased by the national medicare growth factor established for the year under section 8201(c) of the Health Security Act.

"(b) SEPARATE OUT-OF-POCKET LIMIT ON COST-SHARING FOR OUTPATIENT PRESCRIPTION DRUGS.—The amount of cost-sharing incurred in a year with respect to outpatient prescription drugs may not exceed—

"(1) for 1996, \$1,000, increased by the average annual percentage increase in private sector per capita outpatient prescription drug expenditures (as determined by the Secretary) during the 5-year period ending with the second previous year;

"(2) for 1997, the amount applicable under this paragraph for 1996, increased by the average annual percentage increase in private sector per capita outpatient prescription drug expenditures (as determined by the Secretary) during the 5-year period ending with the second previous year; and

"(3) for 1998 and each succeeding year, the amount applicable under this paragraph for the previous year, increased by the percentage increase computed under section 8206(b) for the year.

"SEC. 2113. STANDARD COST-SHARING SCHEDULE DESCRIBED.

"(a) DEDUCTIBLE.—

"(1) IN GENERAL.—Except as provided in paragraphs (3) and (4), with respect to expenses incurred for items and services in the comprehensive benefit package during a year (other than expenses incurred for items and services described in paragraph (2)), the standard cost-sharing schedule offered by a qualified health plan and medicare part C shall have—

"(A) for 1996—

"(i) an annual individual general deductible of \$500, increased by the average annual percentage increase in the per capita gross domestic product (in current dollars, as published by the Secretary of Commerce) during the 5-year period ending with the second previous year, and

"(ii) an annual family general deductible of \$750, increased by such average annual percentage increase;

"(B) for 1997, the annual individual general deductible and the annual family general deductible applicable for 1996, increased by the average annual percentage increase in the per capita gross domestic product (in current dollars, as published by the Secretary of Commerce) during the 5-year period ending with the second previous year; and

"(C) for 1998 and each succeeding year, the annual individual general deductible and the annual family general deductible applicable for the pre-

vious year, increased by the national medicare growth factor established for the year under section 8201(c) of the Health Security Act.

“(2) SEPARATE DEDUCTIBLE FOR COVERED OUTPATIENT DRUGS.—With respect to expenses incurred for covered outpatient drugs in a year, the standard cost-sharing schedule offered by a qualified health plan and medicare part C shall have—

“(A) for 1996, an annual general deductible of \$500, increased by the average annual percentage increase in private sector per capita outpatient prescription drug expenditures (as determined by the Secretary) during the 5-year period ending with the second previous year;

“(B) for 1997, the amount applicable under this paragraph for 1996, increased by the average annual percentage increase in private sector per capita outpatient prescription drug expenditures (as determined by the Secretary) during the 5-year period ending with the second previous year; and

“(C) for 1998 and each succeeding year, the amount applicable under this paragraph for the previous year, increased by percentage increase computed under section 8206(b) of the Health Security Act for the year.

“(3) WAIVER OF DEDUCTIBLE FOR CERTAIN SERVICES.—No deductible shall be applied under the standard cost-sharing schedule offered by a qualified health plan or medicare part C with respect to expenses incurred—

“(A) for newborn and well-baby services (described in section 1861(o)(1);

“(B) for well-child services (described in section 1861(pp)(1); or

“(C) for pregnancy-related services consisting of prenatal services (described in section 1861(s)(20)).

“(4) SPECIAL RULES FOR HIGH DEDUCTIBLE PLAN.—In the case of a high deductible plan (as defined in section 2204(5))—

“(A) the reference in paragraph (1)(A)(i) to ‘\$500’ shall be considered a reference to an amount established by the carrier offering the plan, except that such amount may not be less than \$1,500 and may not exceed \$2,500; and

“(B) the reference in paragraph (1)(A)(ii) to ‘\$750’ shall be considered a reference to an amount established by the carrier offering the plan, except that such amount may not be less than \$2,150 and may not exceed \$3,750.

“(b) APPLICATION OF MEDICARE COINSURANCE RATES AND COPAYMENTS.—

“(1) IN GENERAL.—Except as provided in paragraph (2), the coinsurance rates applicable to an item or service under title XVIII shall apply under the standard cost-sharing schedule offered by a qualified health plan and medicare part C with respect to the same item or service covered under the guaranteed national benefit package.

“(2) WAIVER OF COINSURANCE AND COPAYMENTS FOR CERTAIN SERVICES.—The following waivers of coinsurance and copayments shall apply under the standard cost-sharing schedule offered by a qualified health plan and medicare part C:

“(A) INPATIENT SERVICES.—Inpatient hospital services (as defined in section 1861(b)) and intensive residential services (as defined in section 1861(qq)) shall not be subject to the coinsurance otherwise applicable under the second sentence of section 1813(a)(1).

“(B) POST-HOSPITAL EXTENDED CARE SERVICES.—With respect to post-hospital extended care services (as defined in section 1861(i)) furnished in a skilled nursing facility (as defined in section 1861(j))—

“(i) such services shall not be subject to the coinsurance otherwise applicable under section 1813(a)(3); and

“(ii) such services may be furnished to an individual notwithstanding that the services are not furnished during a spell of illness (as described in section 1861(a)).

“(C) HOME HEALTH SERVICES.—Home health services (as described in section 1861(m)) shall not be subject to the copayment otherwise applicable under section 1813(a)(5) (in the case of services described under part A of title XVIII) or section 1833(a)(2)(G) (in the case of services described under part B of such title).

“SEC. 2114. MANAGED CARE COST-SHARING SCHEDULE.

“(a) IN GENERAL.—Items and services covered under the guaranteed national benefit package provided through a provider network (as defined in section 2204(10)) of a qualified health plan or medicare part C—

“(1) are not subject to a deductible or to payment of any coinsurance (except as may be provided in subsection (b)), and

“(2) are subject to the applicable copayment described in this section.

“(b) COPAYMENTS IMPOSED IN 1996.—

“(1) IN GENERAL.—The copayment applicable under this section with respect to items and services provided during 1996 shall be equal to the following amounts, adjusted in accordance with paragraph (2):

“(A) In the case of physician visits and other health professional visits, \$15.

“(B) In the case of emergency room services (or any other emergency services) for non-emergency treatment, \$30.

“(C) In the case of hospital outpatient and other ambulatory medical and surgical services, \$15.

“(D) In the case of a covered outpatient drug—

“(i) which is a generic product or which is not a generic product if an equivalent generic product is not available, the lesser of \$10 or an amount equal to a coinsurance of 20 percent; or

“(ii) which is not a generic product if an equivalent generic product is available, the greater of \$10 or an amount equal to a coinsurance of 20 percent.

“(E) In the case of pregnancy-related services and family planning services (other than prenatal visits), \$15.

“(F) In the case of intensive community mental illness and substance abuse services, \$30.

“(G) In the case of outpatient mental health and substance abuse services (other than psychotherapy) \$15 per visit.

“(H) In the case of outpatient mental health and substance abuse services consisting of psychotherapy, \$25 per visit.

“(2) INDEXING OF AMOUNTS PROVIDED.—The amounts described in paragraph (1) shall be increased by the average annual percentage increase in the per capita gross domestic product (in current dollars, as published by the Secretary of Commerce) during the 5-year period ending with 1994.

“(c) COPAYMENTS IMPOSED IN SUBSEQUENT YEARS.—The copayment applicable under this section with respect to items and services provided—

“(1) in 1997 is equal to the amount applicable under this section for 1996, increased by the average annual percentage increase in the per capita gross domestic product (in current dollars, as published by the Secretary of Commerce) during the 5-year period ending with the second previous year; and

“(2) in 1998 and each succeeding year is equal to the amount applicable under this section for the previous year, increased by percentage increase computed under section 8206(b) of the Health Security Act for the year.

“(d) COST-SHARING SCHEDULE FOR OUT-OF-NETWORK SERVICES UNDER MANAGED CARE PLANS.—Items and services covered under the guaranteed national benefit package provided under a managed care plan other than through the plan’s provider network (as defined in section 2204(10)) pursuant to section 2219(d) shall be subject to cost-sharing in accordance with a schedule established by the Secretary in consultation with the National Association of Insurance Commissioners.

“PART C—MISCELLANEOUS PROVISIONS

“SEC. 2121. QUALIFIED HEALTH PLAN AND MEDICARE PART C DEFINED.

“In this title, the terms ‘qualified health plan’ and ‘medicare part C’ have the meaning given such terms in section 2 of the Health Security Act.

“SEC. 2122. RELATION BETWEEN PACKAGE AND CERTAIN STATE LAWS.

“(a) PERMITTING STATES TO REQUIRE BENEFITS UNDER QUALIFIED HEALTH PLANS TO BE FURNISHED BY CERTAIN PROVIDERS.—Nothing in this title may be construed to prohibit a State from requiring that an item or service covered under the guaranteed national benefit package be furnished to an individual enrolled in a qualified health plan by any particular class or type of provider who is legally authorized to provide such item or service under the law of the State (or under a State regulatory mechanism provided by State law) in which the item or service is provided.

“(b) REQUIRING HEALTH PLANS TO OFFER BENEFITS IN EXCESS OF NATIONAL PACKAGE.—No State may require a qualified health plan to offer any item or service not included in the guaranteed national benefit package.

“(c) COVERAGE OF SERVICES NOT FURNISHED BY MEDICARE PROVIDERS.—

“(1) IN GENERAL.—Nothing in this part shall be construed to prohibit coverage of an item or service otherwise described in section 2101 under the guaranteed national benefit package furnished to an individual under a qualified health plan solely on the ground that the individual or entity providing the item or service is not an eligible medicare provider, but only if the individual or entity

is legally authorized to provide such item or service under the law of the State (or under a State regulatory mechanism provided by State law) in which the item or service is provided.

“(2) ELIGIBLE MEDICARE PROVIDER DEFINED.—In paragraph (1), an ‘eligible medicare provider’ is an individual or entity providing an item or service for which payment may be made under title XVIII who is participating in such title or otherwise eligible to receive payment for providing such an item or service under such title.

“SEC. 2123. PROVISION OF ITEMS OR SERVICES CONTRARY TO RELIGIOUS BELIEF OR MORAL CONVICTION.

“A health professional or a health facility may not be required to provide an item or service in the guaranteed national benefit package if the professional or facility objects to doing so on the basis of a religious belief or moral conviction.

“SEC. 2124. REFERENCES TO MEDICARE.

“Any reference to title XVIII or any provision of title XVIII in this title shall be deemed to be a reference to such title or such provision as amended by the Health Security Act, except that for any year prior to 1998 for which this title is in effect, any such reference shall be deemed to be a reference to such title or provision as in effect on January 1, 1998.

“SEC. 2125. EXCLUSION OF PAYMENT OF COST-SHARING FOR CERTAIN LOW-INCOME INDIVIDUALS.

“The guaranteed national benefit package established under this title shall not include the waiver of medicare cost-sharing for certain low-income individuals provided under section 1894.

“SEC. 2126. ESTABLISHMENT OF COMMISSIONS.

“(a) ADVISORY COMMISSION ON MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES.—

“(1) ESTABLISHMENT OF COMMISSION.—

“(A) IN GENERAL.—The Director of the Office of Technology Assessment (hereafter in this section referred to as the ‘Director’ and the ‘Office’, respectively) shall provide for the appointment of an Advisory Commission on Mental Health and Substance Abuse Services (hereafter in this subsection referred to as the ‘Commission’) to be composed of individuals appointed by the Director without regard to the provisions of title 5, United States Code, governing appointments in the competitive service.

“(B) NUMBER; TIMING OF APPOINTMENT.—The Commission shall consist of 15 individuals. Members of the Commission shall first be appointed not later than 1 year after the date of the enactment of this subsection for a term of 3 years, except that the Director may provide initially for such shorter terms as will insure that (on a continuing basis) the terms of no more than 4 members expire in any one year.

“(C) COMPOSITION.—The membership of the Commission shall include (but need not be limited to) physicians, other health professionals, individuals with knowledge of and experience in the delivery of mental health and substance abuse services, and representatives of consumers.

“(2) ISSUES STUDIED BY COMMISSION.—The Commission shall examine the following issues:

“(A) The variety of mental health and substance abuse services provided in the United States, together with the types of providers furnishing such services and the methods under which the providers receive payment for furnishing such services.

“(B) The means available to appropriately manage the delivery of mental health and substance abuse services and coordinate the delivery of such services with the delivery of other health services, and to achieve parity in the scope of mental health and substance abuse services covered under the guaranteed national benefit package under this title with the scope of other health services covered under the package.

“(C) The variations in the utilization of and costs associated with mental health and substance abuse services among different geographic regions and demographic groups.

“(D) The incidence and prevalence of severe mental illness and substance abuse among incarcerated adults and juveniles and the relation between the mental health and substance abuse treatment provided to these individuals and the length of time these individuals are incarcerated.

“(E) The standards for training and certifying providers of mental health and substance abuse services.

“(F) The standards used to measure the quality of mental health and substance abuse services and to review the utilization of such services.

“(G) Such other issues relating to mental health and substance abuse services in the United States as the Commission considers appropriate.

“(3) SUBMISSION OF ANNUAL REPORT.—Not later than January 1, 1998 (and not later than January 1 of the first 4 years thereafter), the Commission shall submit to Congress a report—

“(A) describing the issues examined by the Commission under paragraph (2) during the preceding year;

“(B) evaluating the effectiveness of the guaranteed national benefit package under this title in assuring adequate coverage for mental health and substance abuse services;

“(C) analyzing the progress made in achieving parity in the delivery of mental health and substance abuse services and the delivery of other health services for individuals in the United States;

“(D) evaluating State comprehensive managed mental health programs operated during the preceding year under section 4201 of the Health Security Act;

“(E) analyzing trends in the delivery of mental health and substance abuse services and the costs associated with the delivery of such services; and

“(F) analyzing whether any distinctions in limitations on coverage and terminations of payment amounts between mental health and substance abuse services and other services in the guaranteed national benefit package under title XXI should be maintained, modified, or eliminated.

“(4) APPLICABILITY OF OTHER ADMINISTRATIVE PROVISIONS.—The following provisions of section 1886(e)(6) shall apply to the Commission in the same manner as such provisions apply to the Prospective Payment Assessment Commission:

“(A) Subparagraph (C) (relating to staffing and administration generally).

“(B) Subparagraph (D) (relating to compensation of members).

“(C) Subparagraph (F) (relating to access to information).

“(D) Subparagraph (G) (relating to use of funds).

“(E) Subparagraph (H) (relating to periodic GAO audits).

“(F) Subparagraph (J) (relating to requests for appropriations).

“(5) TERMINATION.—The Commission shall terminate 30 days after submitting the final report required under paragraph (3).

“(b) NATIONAL HEALTH ADVISORY COMMISSION.—

“(1) ESTABLISHMENT OF COMMISSION.—

“(A) IN GENERAL.—The Director of the Office of Technology Assessment (hereafter in this section referred to as the ‘Director’ and the ‘Office’, respectively) shall provide for the appointment of a National Health Advisory Commission (hereafter in this subsection referred to as the ‘Commission’).

“(B) COMPOSITION.—The Commission shall consist of the following individuals:

“(i) The Chair and Vice-Chair of the Prospective Payment Assessment Commission.

“(ii) The Chair and Vice-Chair of the Physician Payment Review Commission.

“(iii) The Chair and Vice-Chair of the Prescription Drug Payment Review Commission.

“(iv) The Chair and Vice-Chair of the Advisory Commission on Mental Health and Substance Abuse Services.

“(v) 3 other individuals appointed by the Director (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service) with expertise in health economics, health insurance, benefits, and provider reimbursement.

“(C) TIMING OF APPOINTMENT.—Members of the Commission shall first be appointed not later than 15 months after the date of the enactment of this subsection for a term of 3 years, except that the Director may provide initially for such shorter terms as will insure that (on a continuing basis) the terms of no more than 4 members expire in any one year.

“(2) DUTIES.—Based on detailed information provided by the Commissions referred to in paragraph (1), the Commission shall monitor the impact of the Health Security Act on individuals, employers, and governments.

“(3) ANNUAL REPORTS.—Not later than January 1, 1998, and each January 1 thereafter, the Commission shall submit to Congress a report on the impact of the Health Security Act on individuals, employers, and governments, and shall include in the report recommendations for changes in such Act, including (but

not limited to) changes in the guaranteed national benefit package described in this title.

“(4) APPLICABILITY OF OTHER ADMINISTRATIVE PROVISIONS.—The following provisions of section 1886(e)(6) shall apply to the Commission in the same manner as such provisions apply to the Prospective Payment Assessment Commission:

“(A) Subparagraph (C) (relating to staffing and administration generally).

“(B) Subparagraph (D) (relating to compensation of members).

“(C) Subparagraph (F) (relating to access to information).

“(D) Subparagraph (G) (relating to use of funds).

“(E) Subparagraph (H) (relating to periodic GAO audits).

“(F) Subparagraph (J) (relating to requests for appropriations).”.

SEC. 3002. STUDY ON COVERAGE OF EMERGENCY DENTAL SERVICES.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study of whether coverage for emergency dental services should be included in the guaranteed national benefit package established under part A of title XXI of the Social Security Act (as added by section 3001).

(b) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under subsection (a), and shall include in the report such recommendations as the Secretary considers appropriate regarding the conditions under which emergency dental services should be covered and the methodology under which payment may be made for such services.

Subtitle B—Coverage of Outpatient Prescription Drugs and Other Changes in Medicare Benefits

PART 1—COVERAGE OF OUTPATIENT PRESCRIPTION DRUGS

SEC. 3101. COVERAGE OF OUTPATIENT PRESCRIPTION DRUGS.

(a) COVERED OUTPATIENT DRUGS AS MEDICAL AND OTHER HEALTH SERVICES.—Section 1861(s)(2)(J) (42 U.S.C. 1395x(s)(2)(J)) is amended to read as follows:

“(J) covered outpatient drugs;”.

(b) DEFINITION OF COVERED OUTPATIENT DRUG.—Section 1861(t) (42 U.S.C. 1395x(t)) is amended—

(1) in the heading, by adding at the end the following: “; Covered Outpatient Drugs”;

(2) in paragraph (1)—

(A) by striking “paragraph (2)” and inserting “the succeeding paragraphs of this subsection”, and

(B) by striking the period at the end and inserting “, but only if used for a medically accepted indication (as described in paragraph (4)).”; and

(3) by striking paragraph (2) and inserting the following:

“(2) Except as otherwise provided in paragraph (3), the term ‘covered outpatient drug’ means any of the following products used for a medically accepted indication (as described in paragraph (4)):

“(A) A drug which may be dispensed only upon prescription and—

“(i) which is approved for safety and effectiveness as a prescription drug under section 505 or 507 of the Federal Food, Drug, and Cosmetic Act or which is approved under section 505(j) of such Act;

“(ii)(I) which was commercially used or sold in the United States before the date of the enactment of the Drug Amendments of 1962 or which is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (II) which has not been the subject of a final determination by the Secretary that it is a ‘new drug’ (within the meaning of section 201(p) of the Federal Food, Drug, and Cosmetic Act) or an action brought by the Secretary under section 301, 302(a), or 304(a) of such Act to enforce section 502(f) or 505(a) of such Act; or

“(iii)(I) which is described in section 107(c)(3) of the Drug Amendments of 1962 and for which the Secretary has determined there is a compelling justification for its medical need, or is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (II) for which the Secretary has not issued a notice of an opportunity for a hearing under section 505(e) of the Federal

Food, Drug, and Cosmetic Act on a proposed order of the Secretary to withdraw approval of an application for such drug under such section because the Secretary has determined that the drug is less than effective for all conditions of use prescribed, recommended, or suggested in its labeling.

“(B) A biological product which—

“(i) may only be dispensed upon prescription,

“(ii) is licensed under section 351 of the Public Health Service Act, and

“(iii) is produced at an establishment licensed under such section to produce such product.

“(C) Insulin certified under section 506 of the Federal Food, Drug, and Cosmetic Act.

“(D) Enteral nutrients (but only if provided as a covered home infusion drug).

“(E) Medically-necessary foods for persons with Phenylketonuria (PKU) and other inborn errors of metabolism, in accordance with guidelines developed by the Secretary.

“(3) The term ‘covered outpatient drug’ does not include any product—

“(A) which is administered through infusion in a setting described in paragraph (5)(A)(ii) unless the product is a covered home infusion drug (as defined in paragraph (5));

“(B) when furnished as part of, or as incident to, any other item or service for which payment may be made under this title (other than physicians’ services or services which would be physicians’ services if furnished by a physician); or

“(C) which is listed under paragraph (2) of section 1927(d) (other than subparagraph (B), (I), or (J) of such subparagraph) as a drug which may be excluded from coverage under a State plan under title XIX and which the Secretary elects to exclude from coverage under part B.

“(4) For purposes of paragraph (2), the term ‘medically accepted indication’, with respect to the use of an outpatient drug, includes any use which has been approved by the Food and Drug Administration for the drug, and includes another use of the drug if—

“(A) the drug has been approved by the Food and Drug Administration; and

“(B)(i) such use is supported by one or more citations which are included (or approved for inclusion) in one or more of the following compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluations, the United States Pharmacopoeia-Drug Information, and other authoritative compendia as identified by the Secretary, unless the Secretary has determined that the use is not medically appropriate or the use is identified as not indicated in one or more such compendia, or

“(ii) the carrier involved determines, based upon guidance provided by the Secretary to carriers for determining accepted uses of drugs, that such use is medically accepted based on supportive clinical evidence in peer reviewed medical literature appearing in publications which have been identified for purposes of this clause by the Secretary.

The Secretary may revise the list of compendia in subparagraph (B)(i) designated as appropriate for identifying medically accepted indications for drugs.

“(5)(A) For purposes of paragraph (3), the term ‘covered home infusion drug’ means a covered outpatient drug dispensed to an individual that—

“(i) is administered intravenously, subcutaneously, or epidurally, using an access device that is inserted into the body and an infusion device to control the rate of flow of the drug (or through other means of administration determined by the Secretary);

“(ii) is administered—

“(I) in the individual’s home,

“(II) an institution used as the individual’s home, but only if the drug is administered during an inpatient day for which payment is not made to the institution under part A for inpatient or extended care services furnished to the individual, or

“(III) in a facility other than the individual’s home if the administration of the drug at the facility is determined by the Secretary to be cost-effective (in accordance with such criteria as the Secretary may establish); and

“(iii) with respect to a drug furnished in a home setting—

“(I) is an antibiotic drug and the Secretary has not determined, for the specific drug or the indication to which the drug is applied, that the drug cannot generally be administered safely and effectively in such a setting, or

“(II) is not an antibiotic drug and the Secretary has determined, for the specific drug or the indication to which the drug is applied, that the drug can generally be administered safely and effectively in such a setting.

“(B) Not later than January 1, 1998, (and periodically thereafter), the Secretary shall publish a list of the drugs, and indications for such drugs, that are covered home infusion drugs, with respect to which home infusion drug therapy may be provided under this title.”.

(c) CONFORMING AMENDMENTS REPEALING SEPARATE COVERAGE OF CERTAIN DRUGS AND PRODUCTS.—(1) Effective January 1, 1998, section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

(A) in subparagraph (A), by striking “(including drugs” and all that follows through “self-administered”;

(B) by striking subparagraphs (G) and (I);

(C) by adding “and” at the end of subparagraph (M); and

(D) by striking subparagraphs (O), (P), and (Q).

(2) Effective January 1, 1998, section 1861 (42 U.S.C. 1395x) is amended by striking the subsection (jj) added by section 4156(a)(2) of OBRA-1990.

(3) Effective January 1, 1998, section 1881(b) (42 U.S.C. 1395rr(b)) is amended—

(A) in the first sentence of paragraph (1)—

(i) by striking “, (B)” and inserting “, and (B)”, and

(ii) by striking “, and (C)” and all that follows and inserting a period;

(B) in paragraph (11)—

(i) by striking “(11)(A)” and inserting “(11)”, and

(ii) by striking subparagraphs (B) and (C).

SEC. 3102. PAYMENT RULES AND RELATED REQUIREMENTS FOR COVERED OUTPATIENT DRUGS.

(a) IN GENERAL.—Section 1834 (42 U.S.C. 1395m) is amended by inserting after subsection (c) the following new subsection:

“(d) PAYMENT FOR AND CERTAIN REQUIREMENTS CONCERNING COVERED OUTPATIENT DRUGS.—

“(1) DEDUCTIBLE.—

“(A) IN GENERAL.—Payment shall be made under paragraph (2) only for expenses incurred by an individual for a covered outpatient drug during a calendar year after the individual has incurred expenses in the year for such drugs (during a period in which the individual is entitled to benefits under this part) equal to the deductible amount for that year.

“(B) DEDUCTIBLE AMOUNT.—

“(i) For purposes of subparagraph (A), the deductible amount is—

“(I) for 1998, an amount equal to \$500, increased by the average annual percentage increase in private sector per capita outpatient prescription drug expenditures (as determined by the Secretary) during the 5-year period ending with the second previous year and the percentage increase computed under section 8206(b) of the Health Security Act for 1998; and

“(II) for any succeeding year, the amount applicable under this subparagraph for the previous year, increased by the percentage increase computed under section 8206(b) of the Health Security Act for that succeeding year.

“(ii) The Secretary shall promulgate the deductible amount for 1998 and each succeeding year not later than October 1 of the previous year.

“(2) PAYMENT AMOUNT.—

“(A) IN GENERAL.—Subject to the deductible established under paragraph (1), the amount payable under this part for a covered outpatient drug furnished to an individual during a calendar year shall be equal to—

“(i) 80 percent of the payment basis described in paragraph (3), in the case of an individual who has not incurred expenses for covered outpatient drugs during the year (including the deductible imposed under paragraph (1)) in excess of the out-of-pocket limit for the year under subparagraph (B); and

“(ii) 100 percent of the payment basis described in paragraph (3), in the case of any other individual.

“(B) OUT-OF-POCKET LIMIT DESCRIBED.—

“(i) For purposes of subparagraph (A), the out-of-pocket limit for a year is equal to—

“(I) for 1998, \$1000, increased by the average annual percentage increase in private sector per capita outpatient prescription drug expenditures (as determined by the Secretary) during the 5-year period ending with the second previous year and by the percentage increase computed under section 8206(b) of the Health Security Act for 1998; and

“(II) for any succeeding year, the amount applicable under this subparagraph for the previous year, increased by the percentage increase computed under section 8206(b) of the Health Security Act for that succeeding year.

“(ii) The Secretary shall promulgate the out-of-pocket limit for 1998 and each succeeding year not later than October 1 of the previous year.

“(3) PAYMENT BASIS.—For purposes of paragraph (2), the payment basis is the lesser of—

“(A) the actual charge for a covered outpatient drug, or

“(B) the applicable payment limit established under paragraph (4).

“(4) PAYMENT LIMITS.—

“(A) PAYMENT LIMIT FOR SINGLE SOURCE DRUGS AND MULTIPLE SOURCE DRUGS WITH RESTRICTIVE PRESCRIPTIONS.—In the case of a covered outpatient drug that is a multiple source drug which has a restrictive prescription, or that is single source drug, the payment limit for a payment calculation period is equal to the amount of the administrative allowance (established under paragraph (5)) plus the product of the number of dosage units dispensed and the per unit estimated acquisition cost for the drug product (determined under subparagraph (C)) for the period.

“(B) PAYMENT LIMIT FOR MULTIPLE SOURCE DRUGS WITHOUT RESTRICTIVE PRESCRIPTIONS.—In the case of a drug that is a multiple source drug which does not have a restrictive prescription, the payment limit for a payment calculation period is equal to the amount of the administrative allowance (established under paragraph (5)) plus the product of the number of dosage units dispensed and the unweighted median of the unit estimated acquisition cost (determined under subparagraph (C)) for the drug products for the period.

“(C) DETERMINATION OF UNIT PRICE.—

“(i) INITIAL PAYMENT CALCULATION PERIOD.—Subject to clause (ii), the Secretary shall determine, for the dispensing of a covered outpatient drug product in the payment calculation period beginning January 1, 1998, the estimated acquisition cost for the drug product, based upon—

“(I) in the case of a single source drug or multiple source drug with a restrictive prescription, based upon information from the period beginning in 1994 updated (in a compound manner) by the percentage change in the consumer price index for all urban consumers (U.S. city average) for the 4 12-month periods ending with June 1997; or

“(II) in the case of a multiple source drug without a restrictive prescription, based upon information from the most recent year for which data is available.

“(ii) LIMITATION.—With respect to any covered outpatient drug product, the estimated acquisition cost in the payment calculation period described in clause (i) may not exceed 93 percent of the published average wholesale price for the drug, as determined one month prior to the beginning of the payment calculation period.

“(iii) SUBSEQUENT PERIODS.—The estimated acquisition cost for a covered outpatient drug product applicable under this subparagraph for the dispensing of a drug product in a payment calculation period beginning in January of each year (beginning with 1999) shall be equal to the estimated acquisition cost for the product determined under this subparagraph for the period ending in January of the previous year, increased by the uniform percentage increase determined under section 8206(a) for the class of services that includes prescription drugs for the year involved. Notwithstanding the previous sentence, with respect to any covered outpatient drug product, such cost may not exceed 93 percent of the published average wholesale price for the drug, as determined one month prior to the beginning of the payment calculation period.

“(iv) COMPLIANCE WITH REQUEST FOR INFORMATION.—If a wholesaler or direct seller of a covered outpatient drug refuses, after being requested by the Secretary, to provide price information requested to carry out clauses (i), (ii), or (iii), or deliberately provides information that is false, the Secretary may impose a civil money penalty of not to exceed \$10,000 for each such refusal or provision of false information. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under the previous sentence in the same manner as they apply to a penalty or proceeding under section

1128A(a). Information gathered pursuant to clause (i), (ii), or (iii) shall not be disclosed except as the Secretary determines to be necessary to carry out the purposes of this part and to permit the Comptroller General and the Director of the Congressional Budget Office to review the information provided.

“(D) UPDATES TO PAYMENT LIMITS.—Notwithstanding any other provision of this paragraph, the payment limit determined under this paragraph with respect to a payment calculation period may not exceed the payment limit for the preceding year, increased by the percentage increase computed under section 8206(b) of the Health Security Act.

“(5) ADMINISTRATIVE ALLOWANCE FOR PURPOSES OF PAYMENT LIMIT.—

“(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the administrative allowance established under this paragraph is—

“(i) for 1998, an amount equal to \$5, adjusted by the percentage change in the consumer price index for all urban consumers (U.S. city average) for the 2 12-month periods ending with June 1997; and

“(ii) for each succeeding year, the amount for the previous year, adjusted by the percentage change in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of that previous year.

“(B) REDUCTION FOR MAIL ORDER PHARMACIES.—The Secretary may, after consulting with representatives of pharmacists, individuals enrolled under this part, and of private insurers, reduce the administrative allowances established under subparagraph (A) for any covered outpatient drug dispensed by a mail order pharmacy, based on differences between such pharmacies and other pharmacies with respect to operating costs and other economies.

“(C) NO DISPENSING FEE FOR CERTAIN DRUGS AND PRODUCTS.—No administrative allowance may be provided under this paragraph with respect to any of the following covered outpatient drugs:

“(i) Erythropoietin provided to dialysis patients.

“(ii) Drugs and biologicals provided as an incident to a physician's service or to a service which would be a physician's service if furnished by a physician.

“(iii) Covered home infusion drugs.

“(6) ASSURING APPROPRIATE PRESCRIBING AND DISPENSING PRACTICES.—

“(A) IN GENERAL.—The Secretary shall develop a program to—

“(i) provide on-line prospective review of prescriptions on a 24-hour basis (in accordance with subparagraph (B)) and retrospective review of claims;

“(ii) establish standards for counseling individuals to whom covered outpatient drugs are prescribed; and

“(iii) identify (and to educate physicians, patients, and pharmacists concerning)—

“(I) instances or patterns of unnecessary or inappropriate prescribing or dispensing practices for covered outpatient drugs,

“(II) instances or patterns of substandard care with respect to such drugs,

“(III) potential adverse reactions, and

“(IV) appropriate use of generic products.

“(B) PROSPECTIVE REVIEW.—

“(i) IN GENERAL.—The program under this paragraph shall provide for on-line prospective review of each covered outpatient drug prescribed for a patient before the prescription is filled or the drug is furnished, including screening for potential drug therapy problems due to therapeutic duplication, drug-to-drug interactions, and incorrect drug dosage or duration of drug treatment.

“(ii) DISCUSSION OF APPROPRIATE USE.—In conducting prospective review under this subparagraph, any individual or entity that dispenses a covered outpatient drug shall offer to discuss with the patient to whom the drug is furnished or the patient's caregiver (in person if practicable, or through access to a toll-free telephone service) information regarding the appropriate use of the drug, potential interactions between the drug and other drugs dispensed to the individual, and such other matters as the Secretary may require.

“(iii) ADDITIONAL DUTIES.—In carrying out this subparagraph, the Secretary shall—

- “(I) develop public domain software which could be used by carriers and pharmacies to provide the on-line prospective review; and
- “(II) study the feasibility and desirability of requiring patient diagnosis codes on prescriptions and the feasibility of expanding the prospective review program to include the identification of drug-disease contraindications, interactions with over-the-counter drugs, and drug-allergy interactions.

“(C) PRIOR AUTHORIZATION.—

“(i) DEVELOPMENT OF LIST OF MISUSED DRUGS.—The Secretary shall develop (and periodically) update a list of covered outpatient drugs which the Secretary has determined, based on data collected, may be subject to misuse or inappropriate use. The Secretary shall provide a means for manufacturers to appeal an initial decision to include a drug on the list.

“(ii) PRIOR AUTHORIZATION FOR DRUGS ON LIST.—The Secretary shall establish a process under which (subject to clause (iii)) the Secretary may require advance approval for any covered outpatient drug included on the list developed under clause (i).

“(iii) RESTRICTIONS ON DENIAL OF APPROVAL.—The Secretary may not deny the approval of a drug under the process established under clause (ii) before its dispensing unless the process—

“(I) provides responses by telephone or other telecommunication device within 24 hours of a request for prior authorization; and

“(II) provides for the dispensing of at least a 72-hour supply of a covered outpatient prescription drug in emergency situations.

“(iv) STUDY OF EXPANSION TO OTHER DRUGS.—The Secretary shall study the feasibility and desirability of requiring advance approval under this subparagraph of the dispensing of a covered outpatient drug in cases where a more cost-effective therapeutically equivalent drug is available.

“(D) DRUG USE REVIEW.—As part of the program established under subparagraph (A), the Secretary shall provide for a drug use review program to provide for the ongoing periodic examination of claims data and other records on covered outpatient drugs furnished to patients under this title in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and patients.

“(E) REQUIREMENTS RELATING TO CONTROLLED SUBSTANCES AND ILLEGAL USES.—The Secretary shall require an entity furnishing covered outpatient drugs under this part to report electronically to the appropriate State agency on any covered outpatient drugs dispensed to individuals enrolled under this part that are controlled substances under schedules II through V of the Controlled Substance Act, and on the illegal use or diversion of any such drugs furnished by the entity.

“(F) REPORTS ON DEATHS AND INJURIES RESULTING FROM USE OF DRUGS.—

“(i) IN GENERAL.—The Secretary shall require individuals and entities furnishing items and services for which payment may be made under this title to report electronically to the Secretary on any incidents within the knowledge of the individual or entity of death or serious injury (including initial or prolonged hospitalization, impairment, damage or disruption in the patient's body function, congenital anomaly, or life-threatening outcome) resulting from the prescribing, dispensing, or administration of a covered outpatient drug dispensed to an individual enrolled under this part.

“(ii) PRIVACY PROTECTION.—The Secretary shall establish standards to protect from public disclosure the identity of individuals or institutions that report information under this subparagraph and the identity of any individual (whether a patient or an individual involved in the prescribing, dispensing, or administration of the drug) who is the subject of such information.

“(G) EXCEPTION FOR MANAGED CARE PROGRAMS.—The Secretary may waive the application of any provision of this paragraph to the dispensing of covered outpatient drugs by an organization described in section 1833(a)(1)(A) or an eligible organization with an agreement in effect under section 1876 to the extent the Secretary finds that the organization has in effect a program that meets the objectives of such provision.

“(H) ADOPTION OF MEDICAID PROGRAMS.—To the extent considered appropriate by the Secretary, the program developed under this paragraph with

respect to drugs furnished in a State may include elements applicable to the furnishing of covered outpatient drugs under the State medicaid program under section 1927.

“(7) ADMINISTRATIVE IMPROVEMENTS.—The Secretary shall develop, in consultation with the National Council of Prescription Drug Programs and representatives of pharmacies and of other interested persons, a standard claims form for covered outpatient drugs in accordance with title X of the Health Security Act.

“(8) BILLING REQUIREMENTS.—

“(A) MANDATORY ASSIGNMENT.—(i) Payment under this part for a covered outpatient drug may only be made on an assignment-related basis.

“(ii) Except for deductible, coinsurance, or copayment amounts applicable under this part, no person may bill or collect any amount from an individual enrolled under this part or other person for a covered outpatient drug for which payment may be made under this part, and no such individual or person is liable for payment of any amounts billed in violation of this clause. If a person knowingly and willfully bills or collects an amount in violation of the previous sentence, the Secretary may apply sanctions against such person in accordance with section 1842(j)(2). Paragraph (4) of section 1842(j) shall apply in this clause in the same manner as such paragraph applies to such section.

“(B) USE OF ELECTRONIC SYSTEM.—The Secretary shall establish, by not later than January 1, 1997, a point-of-sale electronic system for use by carriers and pharmacies in the submission of information respecting covered outpatient drugs dispensed to medicare beneficiaries under this part. Such system shall be consistent with the standards established by the National Council of Prescription Drug Programs.

“(9) REQUIRING PHARMACY SUPPLIER NUMBERS.—

“(A) IN GENERAL.—Payment may not be made under this part with respect to a covered outpatient drug furnished by an entity unless the entity has obtained a supplier number from the Secretary.

“(B) STANDARDS FOR ISSUING SUPPLIER NUMBERS.—The Secretary may not issue a supplier number to an entity for purposes of subparagraph (A) unless the entity demonstrates to the Secretary that it will maintain patient records (in accordance with such standards as the Secretary may impose) and meet the other applicable requirements of this subsection and section 1848(g).

“(10) DEFINITIONS.—In this subsection:

“(A) MULTIPLE AND SINGLE SOURCE DRUGS.—The terms ‘multiple source drug’ and ‘single source drug’ have the meanings of those terms under section 1927(k)(7), except that the reference in such section to a ‘covered outpatient drug’ shall be considered a reference to a covered outpatient drug under this part.

“(B) RESTRICTIVE PRESCRIPTION.—A drug has a ‘restrictive prescription’ only if—

“(i) in the case of a written prescription, the prescription for the drug indicates, in the handwriting of the physician or other person prescribing the drug and with an appropriate phrase (such as ‘brand medically necessary’) recognized by the Secretary, that a particular drug product must be dispensed, or

“(ii) in the case of a prescription issued by telephone—

“(I) the physician or other person prescribing the drug (through use of such an appropriate phrase) states that a particular drug product must be dispensed, and

“(II) the physician or other person submits to the pharmacy involved, within 30 days after the date of the telephone prescription, a written confirmation which is in the handwriting of the physician or other person prescribing the drug and which indicates with such appropriate phrase that the particular drug product was required to have been dispensed.

“(C) PAYMENT CALCULATION PERIOD.—The term ‘payment calculation period’ means a calendar year.”.

(b) REQUIRING PHARMACIES TO SUBMIT CLAIMS.—Section 1848(g)(4) (42 U.S.C. 1395w-4(g)(4)) is amended—

(1) in the heading—

(A) by striking “PHYSICIAN”, and

(B) by inserting “BY PHYSICIANS AND SUPPLIERS” after “CLAIMS”;

(2) in the matter in subparagraph (A) preceding clause (i)—

(A) by striking “For services furnished on or after September 1, 1990, within 1 year” and inserting “Within 1 year (or 90 days in the case of covered outpatient drugs)”;

(B) by striking “a service” and inserting “an item or service”, and

(C) by inserting “or of providing a covered outpatient drug,” after “basis,”; and

(3) in subparagraph (A)(i), by inserting “item or” before “service”.

(c) SPECIAL RULES FOR CARRIERS.—

(1) USE OF REGIONAL CARRIERS.—Section 1842(b)(2) (42 U.S.C. 1395u(b)(2)) is amended by adding at the end the following:

“(D) With respect to activities related to covered outpatient drugs, the Secretary may enter into contracts with carriers under this section to perform the activities on a regional basis.”.

(2) ADDITIONAL FUNCTIONS.—Section 1842(b)(3) (42 U.S.C. 1395u(b)(3)) is amended—

(A) by striking “and” at the end of subparagraph (H);

(B) by adding “and” at the end of subparagraph (L);

(C) by redesignating subparagraph (L) as subparagraph (I); and

(D) by inserting after subparagraph (I) (as so redesignated) the following new subparagraphs:

“(J) if it makes determinations or payments with respect to covered outpatient drugs, will—

“(i) receive information transmitted under the electronic system established under section 1834(d)(8)(B), and

“(ii) respond to requests by pharmacies (and individuals entitled to benefits under this part) as to whether or not such an individual has met the prescription drug deductible established under section 1834(d)(1)(A) for a year; and

“(K) will enter into such contracts with organizations described in subsection (f)(3) as the Secretary determines may be necessary to implement and operate (and for related functions with respect to) the electronic system established under section 1834(d)(8)(B) for covered outpatient drugs under this part;”.

(3) PAYMENT ON OTHER THAN A COST BASIS.—Section 1842(c)(1)(A) (42 U.S.C. 1395u(c)(1)(A)) is amended—

(A) by inserting “(i)” after “(c)(1)(A)”,

(B) in the first sentence, by inserting “, except as otherwise provided in clause (ii),” after “under this part, and”, and

(C) by adding at the end the following:

“(ii) To the extent that a contract under this section provides for activities related to covered outpatient drugs, the Secretary may provide for payment for those activities based on any method of payment determined by the Secretary to be appropriate.”.

(4) BATCH PROMPT PROCESSING OF CLAIMS.—Section 1842(c) (42 U.S.C. 1395u(c)) is amended—

(A) in paragraphs (2)(A) and (3)(A), by striking “Each” and inserting “Except as provided in paragraph (4), each”;

(B) by adding at the end the following new paragraph:

“(4)(A) Each contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B), with respect to claims for payment for covered outpatient drugs shall provide for a payment cycle under which each carrier will, on a monthly basis, make a payment with respect to all claims which were received and approved for payment in the period since the most recent date on which such a payment was made with respect to the participating pharmacy or individual submitting the claim.

“(B) If payment is not issued, mailed, or otherwise transmitted within 5 days of when such a payment is required to be made under subparagraph (A), interest shall be paid at the rate used for purposes of section 3902(a) of title 31, United States Code (relating to interest penalties for failure to make prompt payments) for the period beginning on the day after such 5-day period and ending on the date on which payment is made.”.

(5) USE OF OTHER ENTITIES FOR COVERED OUTPATIENT DRUGS.—Section 1842(f) (42 U.S.C. 1395u(f)) is amended—

(A) by striking “and” at the end of paragraph (1),

(B) by striking the period at the end of paragraph (2) and inserting “; and”, and

(C) by adding at the end the following:

"(3) with respect to activities related to covered outpatient drugs, any other private entity which the Secretary determines is qualified to conduct such activities."

(6) DESIGNATED CARRIERS TO PROCESS CLAIMS OF RAILROAD RETIREES.—Section 1842(g) (42 U.S.C. 1395u(g)) is amended by inserting "(other than functions related to covered outpatient drugs)" after "functions".

(e) CONFORMING AMENDMENTS.—

(1)(A) Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended—

(i) by striking "and" at the end of clause (O), and

(ii) by inserting before the semicolon at the end the following: ", and (Q) with respect to covered outpatient drugs, the amounts paid shall be as prescribed by section 1834(d)".

(B) Section 1833(a)(2) (42 U.S.C. 1395l(a)(2)) is amended in the matter preceding subparagraph (A) by inserting ", except for covered outpatient drugs," after "and (I) of such section".

(2) Section 1833(b)(2) (42 U.S.C. 1395l(b)(2)) is amended by inserting "or with respect to covered outpatient drugs" before the comma.

(3) Section 1834(j)(3)(F) (42 U.S.C. 1395m(j)(4)(F)), as added by section 8421(a)(1) and as redesignated by section 8423(a), is amended—

(A) in clause (i), by adding "and" at the end;

(B) by striking clauses (ii), (iv), and (v) and redesignating clause (iii) as clause (ii); and

(C) in clause (ii) (as so redesignated), by striking the comma at the end and inserting a period.

(4) The first sentence of section 1842(h)(2) (42 U.S.C. 1395u(h)(2)) is amended by inserting "(other than a carrier described in subsection (f)(3))" after "Each carrier".

(5) The first sentence of section 1866(a)(2)(A) (42 U.S.C. 1395cc(a)(2)(A)) is amended—

(A) in clause (i), by inserting "section 1834(d)," after "section 1833(b).", and

(B) in clause (ii), by inserting ", other than for covered outpatient drugs," after "provider".

SEC. 3103. MEDICARE REBATES FOR COVERED OUTPATIENT DRUGS.

(a) IN GENERAL.—Part B of title XVIII is amended by adding at the end the following new section:

"REBATES FOR COVERED OUTPATIENT DRUGS

"SEC. 1850. (a) REQUIREMENT FOR REBATE AGREEMENT.—In order for payment to be available under this part for covered outpatient drugs of a manufacturer dispensed or provided on or after January 1, 1998, the manufacturer must have entered into and have in effect a rebate agreement with the Secretary meeting the requirements of subsection (b), and an agreement to give equal access to discounts in accordance with subsection (e).

"(b) TERMS, IMPLEMENTATION, AND ENFORCEMENT OF REBATE AGREEMENT.—

"(1) PERIODIC REBATES.—

"(A) IN GENERAL.—A rebate agreement under this section shall require the manufacturer to pay to the Secretary for each calendar quarter, not later than 30 days after the date of receipt of the information described in paragraph (2) for such quarter, a rebate in an amount determined under subsection (c) for all covered outpatient drugs of the manufacturer described in subparagraph (B).

"(B) DRUGS INCLUDED IN QUARTERLY REBATE CALCULATION.—Drugs subject to rebate with respect to a calendar quarter are drugs which are dispensed by a pharmacy during such quarter to individuals (other than individuals enrolled with an eligible organization with a contract under section 1876) eligible for benefits under this part, as reported by such pharmacies to the Secretary.

"(2) INFORMATION FURNISHED TO MANUFACTURERS.—

"(A) IN GENERAL.—The Secretary shall report to each manufacturer, not later than 60 days after the end of each calendar quarter, information on the total number, for each covered outpatient drug, of units of each dosage form, strength, and package size dispensed under the plan during the quarter, on the basis of the data reported to the Secretary described in paragraph (1)(B).

"(B) AUDIT.—The Comptroller General may audit the records of the Secretary to the extent necessary to determine the accuracy of reports by the

Secretary pursuant to subparagraph (A). Adjustments to rebates shall be made to the extent determined necessary by the audit to reflect actual units of drugs dispensed.

“(3) PROVISION OF PRICE INFORMATION BY MANUFACTURER.—

“(A) QUARTERLY PRICING INFORMATION.—Each manufacturer with an agreement in effect under this section shall report to the Secretary, not later than 30 days after the last day of each calendar quarter, on the average manufacturer retail price and the average manufacturer non-retail price for each dosage form and strength of each covered outpatient drug for the quarter.

“(B) BASE QUARTER PRICES.—Each manufacturer of a covered outpatient drug with an agreement under this section shall report to the Secretary, by not later than 30 days after the effective date of such agreement (or, if later, 30 days after the end of the base quarter), the average manufacturer retail price, for such base quarter, for each dosage form and strength of each such covered drug.

“(C) VERIFICATION OF AVERAGE MANUFACTURER PRICE.—The Secretary may inspect the records of manufacturers, and survey wholesalers, pharmacies, and institutional purchasers of drugs, as necessary to verify prices reported under subparagraph (A).

“(D) PENALTIES.—

“(i) CIVIL MONEY PENALTIES.—The Secretary may impose a civil money penalty on a manufacturer with an agreement under this section—

“(I) for failure to provide information required under subparagraph (A) on a timely basis, in an amount up to \$10,000 per day of delay;

“(II) for refusal to provide information about charges or prices requested by the Secretary for purposes of verification pursuant to subparagraph (C), in an amount up to \$100,000; and

“(III) for provision, pursuant to subparagraph (A) or (B), of information that the manufacturer knows or should know is false, in an amount up to \$100,000 per item of information.

Such civil money penalties are in addition to any other penalties prescribed by law. The provisions of section 1128A (other than subsections (a) (with respect to amounts of penalties or additional assessments) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

“(ii) TERMINATION OF AGREEMENT.—If a manufacturer with an agreement under this section has not provided information required under subparagraph (A) or (B) within 90 days of the deadline imposed, the Secretary may suspend the agreement with respect to covered outpatient drugs dispensed after the end of such 90-day period and until the date such information is reported (but in no case shall a suspension be for less than 30 days).

“(4) LENGTH OF AGREEMENT.—

“(A) IN GENERAL.—A rebate agreement shall be effective for an initial period of not less than one year and shall be automatically renewed for a period of not less than one year unless terminated under subparagraph (B).

“(B) TERMINATION.—

“(i) BY THE SECRETARY.—The Secretary may provide for termination of a rebate agreement for violation of the requirements of the agreement or other good cause shown. Such termination shall not be effective earlier than 60 days after the date of notice of such termination. The Secretary shall afford a manufacturer an opportunity for a hearing concerning such termination, but such hearing shall not delay the effective date of the termination.

“(ii) BY A MANUFACTURER.—A manufacturer may terminate a rebate agreement under this section for any reason. Any such termination shall not be effective until the calendar quarter beginning at least 60 days after the date the manufacturer provides notice to the Secretary.

“(iii) EFFECTIVE DATE OF TERMINATION.—Any termination under this subparagraph shall not affect rebates due under the agreement before the effective date of its termination.

“(iv) NOTICE TO PHARMACIES.—In the case of a termination under this subparagraph, the Secretary shall notify pharmacies and physician or-

ganizations not less than 30 days before the effective date of such termination.

“(c) AMOUNT OF REBATE.—

“(1) BASE REBATE.—Each manufacturer shall remit a basic rebate to the Secretary for each calendar quarter in an amount, with respect to each dosage form and strength of a covered outpatient drug equal to the product of—

“(A) the total number of units subject to rebate for such quarter, as described in subsection (b)(1)(B); and

“(B)(i) in the case of a single-source drug or an innovator-multiple source drug, 15 percent of the average manufacturer retail price, or

“(ii) in the case of a noninnovator-multiple source drug, insulin furnished over-the-counter, or an enteral nutrient, 10 percent of the average manufacturer retail price.

“(2) ADDITIONAL REBATE.—Each manufacturer shall remit to the Secretary, for each calendar quarter, an additional rebate for each dosage form and strength of a single-source or innovator-multiple-source drug, in an amount equal to—

“(A) the total number of units subject to rebate for such quarter, as described in subsection (b)(1)(B), multiplied by

“(B) the amount, if any, by which the average manufacturer retail price for such drugs of the manufacturer exceeds the average manufacturer retail price for the base quarter, increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. average) from the end of such base quarter to the month before the beginning of such calendar quarter.

“(3) DEPOSIT OF REBATES.—The Secretary shall deposit rebates under this section in the Federal Supplementary Medical Insurance Trust Fund established under section 1841.

“(d) CONFIDENTIALITY OF INFORMATION.—Notwithstanding any other provision of law, information disclosed by a manufacturer under this section is confidential and shall not be disclosed by the Secretary (or a carrier), except—

“(A) as the Secretary determines to be necessary to carry out this section,

“(B) to permit the Comptroller General to review the information provided, and

“(C) to permit the Director of the Congressional Budget Office to review the information provided.

“(e) AGREEMENT TO GIVE EQUAL ACCESS TO DISCOUNTS.—An agreement under this subsection by a manufacturer of covered outpatient drugs shall guarantee that the manufacturer will offer, to each wholesaler or retailer (or other purchaser representing a group of such wholesalers or retailers) that purchases such drugs on substantially the same terms (including such terms as prompt payment, cash payment, volume purchase, single-site delivery, the use of formularies by purchasers, and any other terms effectively reducing the manufacturer's costs) as any other purchaser (including any institutional purchaser) the same price for such drugs as is offered to such other purchaser. In determining a manufacturer's compliance with the previous sentence, there shall not be taken into account terms offered to the Department of Veterans Affairs, the Department of Defense, or any public program.

“(f) DEFINITIONS.—For purposes of this section—

“(1) AVERAGE MANUFACTURER RETAIL PRICE.—The term ‘average manufacturer retail price’ means, with respect to a covered outpatient drug of a manufacturer for a calendar quarter, the average price (inclusive of discounts for cash payment, prompt payment, volume purchases, and rebates (other than rebates under this section), but exclusive of nominal prices) paid to the manufacturer for the drug in the United States for drugs distributed to the retail pharmacy class of trade.

“(2) AVERAGE MANUFACTURER NON-RETAIL PRICE.—The term ‘average manufacturer non-retail price’ means, with respect to a covered outpatient drug of a manufacturer for a calendar quarter, the weighted average price (inclusive of discounts for cash payment, prompt payment, volume purchases, and rebates (other than rebates under this section), but exclusive of nominal prices) paid to the manufacturer for the drug in the United States by hospitals and other institutional purchasers that purchase drugs for institutional use and not for resale.

“(3) BASE QUARTER.—The term ‘base quarter’ means, with respect to a covered outpatient drug of a manufacturer, the calendar quarter beginning April 1, 1993, or (if later) the first full calendar quarter during which the drug was marketed in the United States.

“(4) DRUG.—The terms ‘innovator multiple source drug’, ‘noninnovator multiple source drug’, and ‘single source drug’ have the meanings of those terms under section 1927(k)(7), except that the reference in such section to a ‘covered

outpatient drug' shall be considered a reference to a covered outpatient drug under this part.

"(5) MANUFACTURER.—The term 'manufacturer' means, with respect to a covered outpatient drug—

"(A) the entity whose National Drug Code number (as issued pursuant to section 510(e) of the Federal Food, Drug, and Cosmetic Act) appears on the labeling of the drug; or

"(B) if the number described in subparagraph (A) does not appear on the labeling of the drug, the person named as the applicant in a human drug application (in the case of a new drug) or the product license application (in the case of a biological product) for such drug approved by the Food and Drug Administration."

(b) EXCLUSIONS FROM COVERAGE.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(1) by striking "and" at the end of paragraph (15),

(2) by striking the period at the end of paragraph (16) and inserting "; or", and

(3) by inserting after paragraph (16) the following new paragraph:

"(17) consisting of a covered outpatient drug (as described in section 1861(t)) furnished during a year for which the drug's manufacturer does not have in effect a rebate agreement with the Secretary that meets the requirements of section 1850 for the year."

SEC. 3104. PRESCRIPTION DRUG PAYMENT REVIEW COMMISSION.

Part B of title XVIII is amended by adding at the end the following new section:

"PRESCRIPTION DRUG PAYMENT REVIEW COMMISSION

"SEC. 1847. (a)(1) The Director of the Congressional Office of Technology Assessment (in this section referred to as the 'Director' and the 'Office', respectively) shall provide for the appointment of a Prescription Drug Payment Review Commission (in this section referred to as the 'Commission'), to be composed of individuals with expertise in the provision and financing of covered outpatient drugs appointed by the Director (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service).

"(2) The Commission shall consist of 11 individuals. Members of the Commission shall first be appointed by no later than January 1, 1996, for a term of 3 years, except that the Director may provide initially for such shorter terms as will insure that (on a continuing basis) the terms of no more than 4 members expire in any one year.

"(3) The membership of the Commission shall include recognized experts in the fields of health care economics, medicine, pharmacology, pharmacy, and prescription drug reimbursement, as well as at least one individual who is a medicare beneficiary and one individual representing a research-based pharmaceutical and biotechnology company.

"(b)(1) The Commission shall submit to Congress an annual report no later than May 1 of each year, beginning with 1997, concerning methods of determining payment for covered outpatient drugs under this part, including recommendations on the prescription drug allocation of national private and medicare health care expenditure estimates for a year and the annual target rate of increase for such allocation under title VI of the Health Security Act.

"(2) Such report, in 1998 and thereafter, shall include, with respect to the previous year, information on—

"(A) manufacturers' prices for covered outpatient drugs,

"(B) the relation between the costs of covered outpatient drugs and the costs of other items and services provided for the treatment of similar illnesses and conditions,

"(C) increases in manufacturers' prices for covered outpatient drugs and in charges of pharmacists for covered outpatient drugs,

"(D) the level of utilization of covered outpatient drugs by medicare beneficiaries, and

"(E) administrative costs relating to covered outpatient drugs.

"(c) The Commission shall publish a consumer guide to prescription drugs to assist individuals in reducing expenditures for covered outpatient drugs and to assist providers in determining the cost-effectiveness of such drugs.

"(d) Section 1845(c)(1) shall apply to the Commission in the same manner as it applies to the Physician Payment Review Commission.

"(e) There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section. Such sums shall be payable from the Federal

Supplementary Medical Insurance Trust Fund and the Medicare Part C Trust Fund under section 2324, in an allocation that reasonably reflects the proportion of expenditures for outpatient prescription drugs under this part and under part A of title XXIII.”.

SEC. 3105. COVERAGE OF HOME INFUSION DRUG THERAPY SERVICES.

(a) **IN GENERAL.**—Section 1832(a)(2)(A) (42 U.S.C. 1395k(a)(2)(A)) is amended by inserting “and home infusion drug therapy services” before the semicolon.

(b) **HOME INFUSION DRUG THERAPY SERVICES DEFINED.**—Section 1861 (42 U.S.C. 1395x) is amended—

(1) by redesignating the subsection (jj) inserted by section 4156(a)(2) of the Omnibus Budget Reconciliation Act of 1990 as subsection (kk); and

(2) by inserting after such subsection the following new subsection:

“Home Infusion Drug Therapy Services

“(1)(1) The term ‘home infusion drug therapy services’ means the items and services described in paragraph (2) furnished to an individual who is under the care of a physician—

“(A) in a setting described in section 1861(t)(5)(A)(ii),

“(B) by a qualified home infusion drug therapy provider (as defined in paragraph (3)) or by others under arrangements with them made by that provider, and

“(C) under a plan established and periodically reviewed by a physician.

“(2) The items and services described in this paragraph are such nursing, pharmacy, and related services (including medical supplies, intravenous fluids, delivery, and equipment) as are necessary to conduct safely and effectively a drug regimen through use of a covered home infusion drug (as defined in subsection (t)(5)), but do not include such covered home infusion drugs.

“(3) The term ‘qualified home infusion drug therapy provider’ means any entity that the Secretary determines meets the following requirements (or, in the case of a home health agency or an entity with respect to which the only items and services described in paragraph (2) furnished by the entity are enteral nutrition therapy services, meets any of the following requirements which the Secretary considers appropriate):

“(A) The entity is capable of providing or arranging for the items and services described in paragraph (2) and covered home infusion drugs.

“(B) The entity maintains clinical records on all patients.

“(C) The entity adheres to written protocols and policies with respect to the provision of items and services.

“(D) The entity makes services available (as needed) seven days a week on a 24-hour basis.

“(E) The entity coordinates all service with the patient’s physician.

“(F) The entity conducts a quality assessment and assurance program, including drug regimen review and coordination of patient care.

“(G) The entity assures that only trained personnel provide covered home infusion drugs (and any other service for which training is required to provide the service safely).

“(H) The entity assumes responsibility for the quality of services provided by others under arrangements with the entity.

“(I) In the case of an entity in any State in which State or applicable local law provides for the licensing of entities of this nature, the entity (i) is licensed pursuant to such law, or (ii) is approved, by the agency of such State or locality responsible for licensing entities of this nature, as meeting the standards established for such licensing.

“(J) The entity meets such other requirements as the Secretary may determine are necessary to assure the safe and effective provision of home infusion drug therapy services and the efficient administration of the home infusion drug therapy benefit.”.

(c) PAYMENT.—

(1) **IN GENERAL.**—Section 1833 (42 U.S.C. 1395l) is amended—

(A) in subsection (a)(2)(B), by striking “or (E)” and inserting “(E), or (F)”,

(B) in subsection (a)(2)(D), by striking “and” at the end,

(C) in subsection (a)(2)(E), by striking the semicolon and inserting “; and”,

(D) by inserting after subsection (a)(2)(E) the following new subparagraph:

“(F) with respect to home infusion drug therapy services, the amounts described in section 1834(j);”, and

(E) in the first sentence of subsection (b), by striking “services, (3)” and inserting “services and home infusion drug therapy services, (3)”.

(2) AMOUNT DESCRIBED.—Section 1834 is amended by adding at the end the following new subsection:

“(j) HOME INFUSION DRUG THERAPY SERVICES.—

“(1) IN GENERAL.—With respect to home infusion drug therapy services, payment under this part shall be made in an amount equal to the lesser of the actual charges for such services or the fee schedule established under paragraph (2).

“(2) ESTABLISHMENT OF FEE SCHEDULE.—

“(A) IN GENERAL.—The Secretary shall establish by regulation before the beginning of 1998 and each succeeding year a fee schedule for home infusion drug therapy services for which payment is made under this part. A fee schedule established under this subsection shall be on a per diem basis.

“(B) ADJUSTMENT FOR SERVICES FURNISHED BY INSTITUTIONS.—The fee schedule established by the Secretary under subparagraph (A) shall provide for adjustments in the case of home infusion drug therapy services for which payment is made under this part that are furnished by a provider of services to avoid duplicative payments under this title for the service costs associated with such services.”.

(d) CERTIFICATION.—Section 1835(a)(2) (42 U.S.C. 1395n(a)(2)) is amended—

(1) by striking “and” at the end of subparagraph (E),

(2) by striking the period at the end of subparagraph (F) and inserting “; and”, and

(3) by inserting after subparagraph (F) the following:

“(G) in the case of home infusion drug therapy services, (i) such services are or were required because the individual needed such services for the administration of a covered home infusion drug, (ii) a plan for furnishing such services has been established and is reviewed periodically by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician.”.

(e) CERTIFICATION OF HOME INFUSION DRUG THERAPY PROVIDERS; INTERMEDIATE SANCTIONS FOR NONCOMPLIANCE.—

(1) TREATMENT AS PROVIDER OF SERVICES.—Section 1861(u) (42 U.S.C. 1395x(u)) is amended by inserting “home infusion drug therapy provider,” after “hospice program,”.

(2) CONSULTATION WITH STATE AGENCIES AND OTHER ORGANIZATIONS.—Section 1863 (42 U.S.C. 1395z) is amended by striking “and (dd)(2)” and inserting “(dd)(2), and (ll)(3)”.

(3) USE OF STATE AGENCIES IN DETERMINING COMPLIANCE.—Section 1864(a) (42 U.S.C. 1395aa(a)) is amended—

(A) in the first sentence, by striking “an agency is a hospice program” and inserting “an agency or entity is a hospice program or a home infusion drug therapy provider,”; and

(B) in the second sentence—

(i) by striking “institution or agency” and inserting “institution, agency, or entity”, and

(ii) by striking “or hospice program” and inserting “hospice program, or home infusion drug therapy provider”.

(4) APPLICATION OF INTERMEDIATE SANCTIONS.—Section 1846 (42 U.S.C. 1395w-2) is amended—

(A) in the heading, by adding “AND FOR QUALIFIED HOME INFUSION DRUG THERAPY PROVIDERS” at the end,

(B) in subsection (a), by inserting “or that a qualified home infusion drug therapy provider that is certified for participation under this title no longer substantially meets the requirements of section 1861(ll)(3)” after “under this part”, and

(C) in subsection (b)(2)(A)(iv), by inserting “or home infusion drug therapy services” after “clinical diagnostic laboratory tests”.

(f) USE OF REGIONAL INTERMEDIARIES IN ADMINISTRATION OF BENEFIT.—Section 1816 (42 U.S.C. 1395h) is amended by adding at the end the following new subsection:

“(k) With respect to carrying out functions relating to payment for home infusion drug therapy services and covered home infusion drugs, the Secretary may enter into contracts with agencies or organizations under this section to perform such functions on a regional basis.”.

(g) CONFORMING AMENDMENTS.—(1) Section 1834(h)(4)(B) (42 U.S.C. 1395m(h)(4)(B)) is amended by striking “, except that” and all that follows through “equipment”.

(2) Section 1861(n) (42 U.S.C. 1395x(n)) is amended by adding at the end the following: “Such term does not include any home infusion drug therapy services described in section 1861(l) or any covered outpatient drug used as a supply related to the furnishing of an item of durable medical equipment.”.

(3) Section 1861(s)(8) (42 U.S.C. 1395x(s)(8)) is amended by inserting after “dental” the following: “devices or enteral and parenteral nutrients, supplies, and equipment”.

(h) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1998.

PART 2—CHANGES IN MEDICARE BENEFITS TO CONFORM TO GUARANTEED NATIONAL BENEFIT PACKAGE

SEC. 3111. IMPOSITION OF CAP ON OUT-OF-POCKET EXPENDITURES.

(a) IN GENERAL.—Title XVIII is amended by adding at the end the following new section:

“LIMIT ON COST-SHARING INCURRED DURING YEAR

“SEC. 1894. (a) IN GENERAL.—Notwithstanding any other provision of this title, the total amount of cost-sharing incurred by an individual in a year (beginning with 2003) with respect to items and services provided to the individual under this title shall be subject to a limit equal to—

“(1) with respect to items and services furnished in 2003, an amount equal to \$5,500, increased by the average annual percentage increase in the per capita gross domestic product (in current dollars, as published by the Secretary of Commerce) during the 5-year period ending with 1998 and by the national medicare growth factors established for each of the years 1999 through 2003 under section 8201(c) of the Health Security Act; and

“(2) with respect to items and services furnished in any succeeding year, the amount determined under this paragraph for the previous year, increased by the national medicare growth factor established for the year under section 8201(c) of the Health Security Act.

“(b) NOTICE FOR BENEFICIARIES REACHING LIMIT.—The Secretary shall provide each individual, who is determined to have incurred (or has had paid on the individual’s behalf) cost-sharing in a calendar year in the amount described in subsection (a) with a notice that states that the individual has reached the limit on out-of-pocket cost sharing for the year.

“(c) COST-SHARING DEFINED.—In subsection (a), the term ‘cost-sharing’ means expenses incurred by an individual that are attributable to—

“(1) the deductibles and coinsurance described in section 1813;

“(2) the deductibles established under section 1833(b); and

“(3) the difference between the payment amount provided under part B and the payment amount that would be provided if ‘100 percent’ and ‘0 percent’ were substituted for ‘80 percent’ and ‘20 percent’, respectively, each place either appears in sections 1833(a), 1833(i)(2), 1833(i)(3), 1833(n)(1)(B)(i)(II), 1834(a)(1)(A), 1834(c)(1)(C), 1834(h)(1)(A), 1834(i)(1), 1835(b)(2), 1866(a)(2)(A), 1881(b)(2), and 1881(b)(3).”.

(b) LIMIT ON CHARGES WHEN CAP REACHED.—Section 1866(a)(2)(A) (42 U.S.C. 1395cc(a)(2)(A)) is amended by adding at the end the following new sentence: “A provider of services may not impose a charge under the first sentence of this subparagraph for services furnished to an individual during a year after the amount of cost-sharing incurred by the individual during the year reaches the limit on such cost-sharing established under section 1894.”.

SEC. 3112. REPEAL OF LIMIT ON LIFETIME RESERVE DAYS OF INPATIENT HOSPITAL SERVICES.

(a) IN GENERAL.—Section 1812(a)(1) (42 U.S.C. 1395d(a)(1)) is amended by striking “for up to” and all that follows through “payment made”).

(b) CONFORMING AMENDMENTS.—Section 1812 (42 U.S.C. 1395d) is further amended—

(1) in subsection (b), by striking paragraph (1);

(2) by striking subsection (c); and

(3) in subsection (e), by striking “subsections (b) and (c)” and all that follows through “extended care services” and inserting “subsection (b), services”.

(c) **ADMINISTRATION; TRANSITION.**—The Secretary of Health and Human Services may take such actions as the Secretary finds appropriate to adjust the payments made to hospitals under title XVIII of the Social Security Act for hospital services to take into account the amendments made by this section.

SEC. 3113. COVERAGE OF SERVICES FOR INFANTS AND CHILDREN.

(a) **SERVICES DESCRIBED.**—Section 1861(s) (42 U.S.C. 1395x(s)(2)) is amended—

(1) by striking “and” at the end of paragraph (12);

(2) by striking the period at the end of paragraph (14) and inserting “; and”; and

(3) by inserting after paragraph (14) the following new paragraphs:

“(15) newborn and well-baby services (as defined in subsection (oo)(1));”.

“(16) well-child services (as defined in subsection (pp)(1)) provided to an individual who is under 19 years of age; and

“(17) medically necessary and appropriate hearing aids provided to an individual who is under 19 years of age (in accordance with such periodicity schedule as the Secretary may establish in consultation with the Academy of Otolaryngology-Head and Neck Surgery and the American Speech-Language Hearing Association).”.

(b) **SERVICES DEFINED.**—

(1) **IN GENERAL.**—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

“Newborn and Well-Baby Services

“(oo)(1) The term ‘newborn and well-baby services’ means well-baby care, including routine office visits, routine immunizations (including the vaccine itself), routine laboratory tests (including lead screening), and includes the services of pediatricians during high-risk delivery (as determined in accordance with criteria established by the Secretary).

“(2) The Secretary, in consultation with the American Academy of Pediatrics and other entities considered appropriate by the Secretary, shall establish a schedule of periodicity which reflects the appropriate frequency with which the services referred to in paragraph (1) should be provided.”.

“Well-Child Services

“(pp)(1) The term ‘well-child services’ means well-child care, including routine office visits, routine immunizations (including the vaccine itself), routine laboratory tests (including lead screening in accordance with recommendations of the Centers for Disease Control and Prevention), child abuse assessment, and dental care (including preventive dental services described in paragraph (2), routine fillings, and oral surgery), provided in accordance with the periodicity schedule established with respect to the services under paragraph (3).

“(2) In paragraph (1), the term ‘preventive dental services’ means oral dental examinations, radiographs, dental sealants, fluoride application, and dental prophylaxis.

“(3) The Secretary, in consultation with the American Academy of Pediatrics, the Academy of Pediatric Dentistry, and other entities considered appropriate by the Secretary, shall establish a schedule of periodicity which reflects the appropriate frequency with which the services referred to in paragraph (1) should be provided to healthy children.”.

(2) **CONFORMING AMENDMENTS.**—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(A) in paragraph (1)—

(i) in subparagraph (E), by striking “and” at the end,

(ii) in subparagraph (F), by striking the semicolon at the end and inserting a comma, and

(iii) by adding at the end the following new subparagraphs:

“(G) in the case of newborn and well-baby services, which are performed more frequently than is provided under the schedule of periodicity established by the Secretary under section 1861(oo)(2) for such services, and

“(H) in the case of well-child services, which are provided more frequently than is provided under the schedule of periodicity established by the Secretary under section 1861(pp)(2) for such services;” and

(B) in paragraph (7), by striking “section 1861(s)(10) and paragraph (1)(B) or under paragraph (1)(F)” and inserting “section 1861(s)(10), section 1861(s)(17), and subparagraphs (B), (F), (G), or (H) of paragraph (1)”.

(3) PAYMENT; WAIVER OF COST-SHARING.—

(A) AMOUNT OF PAYMENT; WAIVER OF COINSURANCE.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)), as amended by section 3102(e)(1)(A), is amended—

(i) by striking “and (Q)” and inserting “(Q)”; and

(ii) by striking the semicolon at the end and inserting the following: “, (R) with respect to newborn and well-baby services (as described in section 1861(o)(1)), the amounts paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph, and (S) with respect to well-child services (as described in section 1861(pp)(1)), the amounts paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph.”.

(B) WAIVER OF DEDUCTIBLE.—The first sentence of section 1833(b) (42 U.S.C. 1395l(b)) is amended—

(i) by striking “and (5)” and inserting “(5)”; and

(ii) by striking the period at the end and inserting the following: “, (6) such deductible shall not apply with respect to newborn and well-baby services (as described in section 1861(o)(1)), and (7) such deductible shall not apply with respect to well-child services (as described in section 1861(pp)(1)).”.

(4) CLARIFICATION OF COVERAGE OF CERTAIN REHABILITATION SERVICES.—Section 1861(p) (42 U.S.C. 1395x(p)) is amended by adding at the end the following: “Nothing in this section or section 1862(a)(1)(A) shall be construed to exclude any rehabilitation service otherwise treated as an outpatient physical therapy service under this section on the ground that the service is furnished to a child under 19 years of age with a congenital condition.”.

(c) GENERAL CONFORMING AMENDMENTS.—The Social Security Act is amended—

(1) in section 1861(s)(2)(C) (42 U.S.C. 1395x(s)(2)(C)), by striking “(C)” and inserting “(C) subject to section 1890(b)”;.

(2) in section 1861(s)(3) (42 U.S.C. 1395x(s)(3)), by striking “(3)” and inserting “(3) subject to section 1890(a)”;.

(3) by striking the second and third sentences of section 1861(s); and

(4) by inserting after section 1889 the following new section:

“SPECIAL RULES FOR LABORATORY AND DIAGNOSTIC TESTS AND SERVICES

“SEC. 1890. (a) REQUIRING DIAGNOSTIC LABORATORY AND SCREENING TESTS TO BE FURNISHED IN CERTIFIED SETTINGS.—No payment may be made under this title for any diagnostic and screening test performed in any laboratory (including a laboratory that is part of a rural health clinic or any institution considered a hospital for purposes of section 1814(d)), including a routine laboratory test for purposes of section 1861(o)(1) or section 1861(pp)(1), unless such laboratory meets the following requirements:

“(1) If the laboratory is situated in any State in which State or applicable local law provides for licensing of establishments of this nature, the laboratory—

“(A) is licensed pursuant to such law, or

“(B) is approved, by the agency of such State or locality responsible for licensing establishments of this nature, as meeting the standards established for such licensing.

“(2) The laboratory meets—

“(A) the certification requirements under section 353 of the Public Health Service Act; and

“(B) such other conditions relating to the health and safety of individuals with respect to whom such tests are performed as the Secretary may find necessary.

“(b) EXCLUSION OF DIAGNOSTIC SERVICES NOT MEETING REQUIREMENTS FOR INPATIENT HOSPITAL SERVICES.—

“(1) IN GENERAL.—No item or service may be included as a diagnostic service specified in section 1861(s)(2)(C) if the item or service would not be included as an inpatient hospital service under section 1861(b) if furnished to an inpatient of a hospital.

“(2) EXCEPTION FOR PHYSICIANS’ SERVICES.—Paragraph (1) shall not apply with respect to any service consisting of a physicians’ service.”; and
 (5) by striking “paragraphs (15) and (16) of section 1861(s)” each place it appears in section 1864(a) and the third sentence of section 1865(a) and inserting “subsections (a) and (b) of section 1890”.

SEC. 3114. EXPANDING COVERAGE OF PREVENTIVE BENEFITS.

(a) ANNUAL SCREENING MAMMOGRAPHY FOR WOMEN OVER AGE 49.—Section 1834(c)(2)(A) (42 U.S.C. 1395m(c)(2)(A)) is amended—

(1) in clause (iv), by striking “but under 65 years of age,”; and

(2) by striking clause (v).

(b) COVERAGE OF SCREENING PAP SMEAR AND PELVIC EXAMS.—

(1) COVERAGE OF PELVIC EXAM; INCREASING FREQUENCY OF COVERAGE OF PAP SMEAR.—Section 1861(nn) (42 U.S.C. 1395x(nn)) is amended—

(A) in the heading, by striking “Smear” and inserting “Smear; Screening Pelvic Exam”;

(B) by striking “(nn)” and inserting “(nn)(1)”;

(C) by striking “3 years” and all that follows and inserting “3 years, or during the preceding year in the case of a woman described in paragraph (3).”; and

(D) by adding at the end the following new paragraphs:

“(2) The term ‘screening pelvic exam’ means an pelvic examination provided to a woman if the woman involved has not had such an examination during the preceding 3 years, or during the preceding year in the case of a woman described in paragraph (3), and includes a clinical breast examination.

“(3) A woman described in this paragraph is a woman who—

“(A) is of childbearing age and has not had a test described in this subsection during each of the preceding 3 years that did not indicate the presence of cervical cancer; or

“(B) is at high risk of developing cervical cancer (as determined pursuant to factors identified by the Secretary).”.

(2) CONFORMING AMENDMENTS.—(A) Section 1861(s)(14) (42 U.S.C. 1395x(s)(14)) is amended by inserting “and screening pelvic exam” after “screening pap smear”.

(B) Section 1862(a)(1)(F) (42 U.S.C. 1395y(a)(1)(F)) is amended by inserting “and screening pelvic exam” after “screening pap smear”.

(c) COVERAGE OF COLORECTAL SCREENING.—

(1) IN GENERAL.—Section 1834 (42 U.S.C. 1395m), as amended by section 3102(a), is amended by inserting after subsection (d) the following new subsection:

“(e) FREQUENCY AND PAYMENT LIMITS FOR SCREENING FECAL-OCCULT BLOOD TESTS, SCREENING FLEXIBLE SIGMOIDOSCOPIES, AND SCREENING COLONOSCOPY.—

“(1) SCREENING FECAL-OCCULT BLOOD TESTS.—

“(A) LIMITING COVERAGE FOR NON-ELDERLY TO HIGH-RISK INDIVIDUALS.—No payment may be made under this part for a screening fecal-occult blood test provided for the purpose of early detection of colon cancer to an individual who is under 65 years of age unless the individual is at high risk for colorectal cancer (as determined in accordance with criteria established by the Secretary).

“(B) FREQUENCY LIMITS.—Subject to revision by the Secretary under paragraph (4), no payment may be made under this part for a screening fecal-occult blood test provided to an individual for the purpose of early detection of colon cancer if the test is performed—

“(i) in the case of an individual under 65 years of age, more frequently than is provided in a periodicity schedule established by the Secretary for purposes of this subparagraph; or

“(ii) in the case of any other individual, within the 11 months following the month in which a previous screening fecal-occult blood test was performed.

“(2) SCREENING FLEXIBLE SIGMOIDOSCOPIES.—

“(A) PAYMENT AMOUNT.—The Secretary shall establish a payment amount under section 1848 with respect to screening flexible sigmoidoscopies provided for the purpose of early detection of colon cancer that is consistent with payment amounts under such section for similar or related services, except that such payment amount shall be established without regard to subsection (a)(2)(A) of such section.

“(B) LIMITING COVERAGE FOR NON-ELDERLY TO HIGH-RISK INDIVIDUALS.—No payment may be made under this part for a screening flexible

sigmoidoscopy provided for the purpose of early detection of colon cancer to an individual who is under 65 years of age unless the individual is at high risk for colorectal cancer (as determined in accordance with criteria established by the Secretary).

“(C) FREQUENCY LIMITS.—Subject to revision by the Secretary under paragraph (4), no payment may be made under this part for a screening flexible sigmoidoscopy provided to an individual for the purpose of early detection of colon cancer if the procedure is performed—

“(i) in the case of an individual under 65 years of age, more frequently than is provided in a periodicity schedule established by the Secretary for purposes of this subparagraph; or

“(ii) in the case of any other individual, within the 59 months following the month in which a previous screening flexible sigmoidoscopy was performed.

“(3) SCREENING COLONOSCOPY FOR INDIVIDUALS AT HIGH RISK FOR COLORECTAL CANCER.—

“(A) PAYMENT AMOUNT.—The Secretary shall establish a payment amount under section 1848 with respect to screening colonoscopy for individuals at high risk for colorectal cancer (as determined in accordance with criteria established by the Secretary) provided for the purpose of early detection of colon cancer that is consistent with payment amounts under such section for similar or related services, except that such payment amount shall be established without regard to subsection (a)(2)(A) of such section.

“(B) FREQUENCY LIMIT.—Subject to revision by the Secretary under paragraph (4), no payment may be made under this part for a screening colonoscopy for individuals at high risk for colorectal cancer provided to an individual for the purpose of early detection of colon cancer if the procedure is performed within the 47 months following the month in which a previous screening colonoscopy was performed.

“(C) FACTORS CONSIDERED IN ESTABLISHING CRITERIA FOR DETERMINING INDIVIDUALS AT HIGH RISK.—In establishing criteria for determining whether an individual is at high risk for colorectal cancer for purposes of this paragraph, the Secretary shall take into consideration family history, prior experience of cancer, a history of chronic digestive disease condition, and the presence of any appropriate recognized gene markers for colorectal cancer.

“(4) REVISION OF FREQUENCY.—

“(A) REVIEW.—The Secretary shall review periodically the appropriate frequency for performing screening fecal-occult blood tests, screening flexible sigmoidoscopies, and screening colonoscopy based on age and such other factors as the Secretary believes to be pertinent.

“(B) REVISION OF FREQUENCY.—The Secretary, taking into consideration the review made under clause (i), may revise from time to time the frequency with which such tests and procedures may be paid for under this subsection, but no such revision shall apply to tests or procedures performed before January 1, 2002.

“(5) LIMITING CHARGES OF NONPARTICIPATING PHYSICIANS.—

“(A) IN GENERAL.—In the case of a screening flexible sigmoidoscopy provided to an individual for the purpose of early detection of colon cancer or a screening colonoscopy provided to an individual at high risk for colorectal cancer for the purpose of early detection of colon cancer for which payment may be made under this part, if a nonparticipating physician provides the procedure to an individual enrolled under this part, the physician may not charge the individual more than the limiting charge (as defined in section 1848(g)(2)).

“(B) ENFORCEMENT.—If a physician or supplier knowing and willfully imposes a charge in violation of subparagraph (A), the Secretary may apply sanctions against such physician or supplier in accordance with section 1842(j)(2).”.

(2) CONFORMING AMENDMENTS.—(A) Paragraphs (1)(D) and (2)(D) of section 1833(a) (42 U.S.C. 1395l(a)) are each amended by striking “subsection (h)(1),” and inserting “subsection (h)(1) or section 1834(e)(1),”.

(B) Clauses (i) and (ii) of section 1848(a)(2)(A) (42 U.S.C. 1395w-4(a)(2)(A)) are each amended by striking “a service” and inserting “a service (other than a screening flexible sigmoidoscopy provided to an individual for the purpose of early detection of colon cancer or a screening colonoscopy provided to an individual at high risk for colorectal cancer for the purpose of early detection of colon cancer)”.

(C) Section 1861(s) (42 U.S.C. 1395x(s)) as amended by section 3113(a), is amended—

(i) by striking “and” at the end of paragraph (16);

(ii) by striking the period at the end of paragraph (17) and inserting “; and”;

(iii) by inserting after paragraph (17) the following new paragraph:

“(18) screening fecal-occult blood tests, screening flexible sigmoidoscopies, and screening colonoscopy provided for the purpose of early detection of colon cancer.”

(D) Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 3113(b)(2), is amended—

(i) in paragraph (1)—

(I) in subparagraph (G), by striking “and” at the end;

(II) in subparagraph (H), by striking the semicolon at the end and inserting “, and”;

(III) by adding at the end the following new subparagraph:

“(I) in the case of screening fecal-occult blood tests, screening flexible sigmoidoscopies, and screening colonoscopy provided for the purpose of early detection of colon cancer, which are performed more frequently than is covered under section 1834(e);”;

(ii) in paragraph (7), by striking “or (H)” and inserting “(H), or (I)”.

(d) COVERAGE OF SCREENING FOR SEXUALLY-TRANSMITTED DISEASES.—

(1) IN GENERAL.—Section 1861(s) (42 U.S.C. 1395x(s)(2)), as amended by section 3113(a) and subsection (c)(2)(D), is amended—

(1) by striking “and” at the end of paragraph (17);

(2) by striking the period at the end of paragraph (18) and inserting “; and”;

(3) by inserting after paragraph (18) the following new paragraph:

“(19) screening for chlamydial infection and gonorrhea for a woman over 12 years of age and under 50 years of age who is at risk for sexually-transmitted disease (as determined pursuant to factors identified by the Secretary) and who has not had such a screening during the preceding 1-year period.”

(2) CONFORMING AMENDMENT.—Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 3113(b)(2) and subsection (c)(2)(D), is amended—

(i) in paragraph (1)—

(I) in subparagraph (H), by striking “and” at the end;

(II) in subparagraph (I), by striking the semicolon at the end and inserting “, and”;

(III) by adding at the end the following new subparagraph:

“(J) in the case of screening for chlamydia and gonorrhea, which is performed more frequently than is covered under section 1861(s)(19);”;

(ii) in paragraph (7), by striking “or (I)” and inserting “(I), or (J)”.

SEC. 3115. COVERAGE OF PREGNANCY-RELATED SERVICES AND FAMILY PLANNING.

(a) IN GENERAL.—Section 1861(s) (42 U.S.C. 1395x(s)(2)), as amended by sections 3113(a), 3114(c)(2)(D), and 3114(d)(1), is amended—

(1) by striking “and” at the end of paragraph (18);

(2) by striking the period at the end of paragraph (19) and inserting “; and”;

(3) by inserting after paragraph (19) the following new paragraphs:

“(20) pregnancy-related services; and

“(21) voluntary family planning services, including contraceptive devices that—

“(A) may only be dispensed upon prescription, and

“(B) are subject to approval by the Secretary under the Federal Food, Drug, and Cosmetic Act.”

(b) PAYMENT FOR SERVICES; WAIVER OF COINSURANCE AND DEDUCTIBLE FOR PRE-NATAL SERVICES.—

(1) AMOUNT OF PAYMENT; WAIVER OF COINSURANCE FOR PRENATAL SERVICES.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)), as amended by sections 3102(f) and 3113(b)(3), is amended—

(A) by striking “and (S)” and inserting “(S)”; and

(B) by striking the semicolon at the end and inserting the following: “, (T) with respect to pregnancy-related services (as described in section 1861(s)(20)), the amounts paid shall be 80 percent (or, in the case of services consisting of prenatal services, 100 percent) of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph, and (U) with

respect to voluntary family planning services (described in section 1861(s)(21)), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph;".

(2) **WAIVER OF DEDUCTIBLE FOR PRENATAL SERVICES.**—The first sentence of section 1833(b), (42 U.S.C. 1395l(b)) as amended by section 3113(b)(3), is amended—

- (A) by striking "and (7)" and inserting "(7)"; and
- (B) by striking the period at the end and inserting the following: "; and
- (8) such deductible shall not apply with respect to pregnancy-related services consisting of prenatal services (described in section 1861(s)(20)).".

SEC. 3116. EXPANDING COVERAGE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES.

(a) **INPATIENT PSYCHIATRIC HOSPITAL SERVICES.**—

(1) **SERVICES COVERED.**—Section 1812(a) (42 U.S.C. 1395d(a)) is amended—

- (A) by striking "and" at the end of paragraph (3);
- (B) by striking the period at the end of paragraph (4) and inserting "and"; and
- (C) by adding at the end the following new paragraph:

"(5) inpatient hospital services furnished primarily for the diagnosis or treatment of mental illness or substance abuse for up to 60 days during a year."

(2) **LIMITATION ON COVERAGE.**—Section 1812(b)(3) (42 U.S.C. 1395d(b)) is amended to read as follows:

"(3) inpatient hospital services furnished primarily for the diagnosis or treatment of mental illness or substance abuse that are furnished to the individual during a year after such services have been furnished to the individual for a total of 60 days during the year."

(3) **CONFORMING AMENDMENTS.**—(A) Section 1812(a)(1) (42 U.S.C. 1395d(a)(1)) is amended by inserting "(other than services described in paragraph (5))" after "inpatient hospital services" the first place it appears.

(B) Section 1812(b)(1) (42 U.S.C. 1395d(b)(1)) is amended by inserting "(other than services described in paragraph (3))" after "inpatient hospital services" the first place it appears.

(C) Section 1812 (42 U.S.C. 1395d) is amended by striking subsection (c).

(D) Section 1814(a) (42 U.S.C. 1395f(a)) is amended—

- (i) in paragraph (2), by striking subparagraph (A);
- (ii) in paragraph (3), by striking "(other than inpatient psychiatric hospital services)"; and
- (iii) by striking paragraph (4).

(E) Section 1861 (42 U.S.C. 1395x) is amended by striking subsection (c).

(4) **EFFECTIVE DATE; TRANSITION.**—The amendments made by this section shall take effect January 1, 1998, except that—

(A) an individual who at any time prior to such date has been furnished inpatient psychiatric services (as defined for purposes of title XVIII of the Social Security Act as of the date of the enactment of this Act) for 190 consecutive days is not entitled to any services under section 1812(a)(5) (as added by paragraph (1)(C)); and

(B) in the case of an individual who is not described in subparagraph (A) and is receiving inpatient psychiatric hospital services (as defined for purposes of title XVIII of the Social Security Act as of the date of the enactment of this Act) on December 31, 1997, for which payment may be made under section 1812 of such Act, the number of days of services for which the individual is entitled under section 1812(a)(5) (and the number of days applicable under section 1812(b)(3)) shall be equal to the greater of 60 or the difference between 190 days and the number of days of such inpatient psychiatric hospital services furnished to the individual prior to January 1, 1998.

(b) **INTENSIVE RESIDENTIAL SERVICES.**—

(1) **COVERAGE UNDER PART A.**—Section 1812(a) (42 U.S.C. 1395d(a)), as amended by subsection (a)(1), is amended—

- (A) by striking "and" at the end of paragraph (4);
- (B) by striking the period at the end of paragraph (5) and inserting "and"; and
- (C) by adding at the end the following new paragraph:

"(6) intensive residential services (as described in section 1861(qq)) furnished to an individual for up to 120 days during any calendar year, except that such services may be furnished to the individual for additional days during the year if necessary for the individual to complete a course of treatment to the extent

that the number of days of inpatient hospital services described in paragraph (5) that may be furnished to the individual during the year (as reduced under such paragraph) is not less than 15.”.

(2) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395x), as amended by section 3113(b), is further amended by adding at the end the following new subsection:

“Intensive Residential Services

“(qq)(1) Subject to paragraph (2), the term ‘intensive residential services’ means inpatient services provided in any of the following facilities:

“(A) Residential detoxification centers.

“(B) Crisis residential programs or mental illness residential treatment programs.

“(C) Therapeutic family or group treatment homes.

“(D) Residential centers for substance abuse treatment.

“(2) No service may be treated as an intensive residential service under paragraph (1) unless the facility at which the service is provided—

“(A) is legally authorized to provide such service under the law of the State (or under a State regulatory mechanism provided by State law) in which the facility is located or is certified to provide such service by an appropriate accreditation entity approved by the Secretary; and

“(B) meets such other requirements as the Secretary may impose to assure the quality of the intensive residential services provided.

“(3) No service may be treated as an intensive residential service under paragraph (1) unless the service is furnished in accordance with standards established by the Secretary for the management of such services.”.

(3) REDUCTION IN DAYS OF COVERAGE FOR INPATIENT SERVICES.—Section 1812(a)(5) and section 1812(b)(3), as amended by subsection (a), are each amended by striking the period at the end and inserting the following: “, reduced by a number of days determined by the Secretary so that the actuarial value of providing such number of days of services under this paragraph to the individual is equal to the actuarial value of the days of inpatient residential services furnished to the individual under paragraph (6) during the year after such services have been furnished to the individual for 120 days during the year (rounded to the nearest day).”.

(4) AMOUNT OF PAYMENT.—Section 1814 (42 U.S.C. 1395f) is amended—

(A) in subsection (b) in the matter preceding paragraph (1), by inserting “other than intensive residential services,” after “hospice care,”; and

(B) by adding at the end the following new subsection:

“Payment for Intensive Residential Services

“(m) The amount of payment under this part for intensive residential services under section 1812(a)(6) shall be equal to—

“(1) the lesser of—

“(A) the reasonable cost of such services, as determined under section 1861(v), or

“(B) the customary charges with respect to such services, less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A):

“(2) if such services are furnished by a public provider of services or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this clause), free of charge or at nominal charges to the public, the amount determined in accordance with subsection (b)(2); and

“(3) if (and for so long as) the conditions described in subsection (b)(3) are met, the amounts determined under the reimbursement system described in such section.”.

(c) LOWERING COINSURANCE FOR CERTAIN OUTPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES.—

(1) IN GENERAL.—Section 1833(c) (42 U.S.C. 1395l(c)) is amended by striking “mental, psychoneurotic, and personality disorders” and all that follows through “are incurred” and inserting the following: “mental illness or substance abuse of an individual who, at the time such expenses are incurred, is over 18 years of age, is not an inpatient of a hospital, and has received 5 or more sessions of such treatment during the calendar year.”.

(2) REQUIRING SERVICES TO BE FURNISHED IN ACCORDANCE WITH MANAGEMENT STANDARDS.—Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 3103(b), is amended—

(A) by striking “and” at the end of paragraph (16);

(B) by striking the period at the end of paragraph (17) and inserting “; or”; and

(C) by inserting after paragraph (17) the following:

“(18) in the case of any items or services furnished under part B for the treatment of mental illness or emotional disturbance (including substance abuse), if the services are not furnished in accordance with standards established by the Secretary for the management of such services.”.

(d) INTENSIVE COMMUNITY-BASED SERVICES.—

(1) COVERAGE.—Section 1832(a)(2)(J) (42 U.S.C. 1395k(a)(2)(J)) is amended to read as follows:

“(J) intensive community-based services (as described in section 1861(ff))—

“(i) for an unlimited number of days during any calendar year, in the case of services described in section 1861(ff)(2)(L) that are furnished to an individual who is a seriously mentally ill adult, a seriously emotionally disturbed child, or an adult or child with serious substance abuse disorder (as determined in accordance with criteria established by the Secretary),

“(ii) for up to 180 days during any calendar year, in the case of services described in section 1861(ff)(2)(J), or

“(iii) for up to 90 days, in the case of any other such services.”.

(2) SERVICES DESCRIBED.—Section 1861(ff)(2) (42 U.S.C. 1395x(ff)(2)) is amended—

(A) in subparagraph (C)—

(i) by inserting “behavioral aide services,” after “nurses”, and

(ii) by adding at the end the following: “(to the extent authorized under State law)”;

(B) by striking “and” at the end of subparagraph (H);

(C) by redesignating subparagraph (I) as subparagraph (N); and

(D) by inserting after subparagraph (H) the following new subparagraphs:

“(I) psychiatric rehabilitation services,

“(J) day treatment services for individuals under 19 years of age,

“(K) in-home services,

“(L) case management services,

“(M) ambulatory detoxification services, and”.

(3) PERMITTING NON-PHYSICIAN PROVIDERS TO SUPERVISE INDIVIDUAL PROGRAM OF TREATMENT.—Section 1861(ff)(1) (42 U.S.C. 1395x(ff)(1)) is amended by inserting after “supervision of a physician” the following: “(or, to the extent permitted under the law of the State in which the services are furnished, a non-physician mental health professional)”.

(4) REQUIRING SERVICES TO MEET MANAGEMENT STANDARDS.—Section 1861(ff)(1) (42 U.S.C. 1395x(ff)(1)) is amended by striking the period at the end and inserting the following: “, but does not include any item or service that is not furnished in accordance with standards established by the Secretary for the management of such services.”.

(5) PROGRAMS ELIGIBLE TO PROVIDE SERVICES.—Section 1861(ff)(3) (42 U.S.C. 1395x(ff)(3)) is amended to read as follows:

“(3) A program described in this paragraph is a program (whether facility-based or freestanding) which is furnished by an entity—

“(A) legally authorized to furnish such a program under State law (or the State regulatory mechanism provided by State law) or certified to furnish such a program by an appropriate accreditation entity approved by the Secretary; and

“(B) meeting such other requirements as the Secretary may impose to assure the quality of the intensive residential services provided.”.

(6) WAIVER OF COPAYMENT FOR CASE MANAGEMENT SERVICES FURNISHED TO CERTAIN INDIVIDUALS.—Section 1832(a)(3) (42 U.S.C. 1395k(a)(2)) is amended—

(A) in subparagraph (B), by striking “or (E)” and inserting “(E), or (F)”;

(B) by striking “and” at the end of subparagraph (D);

(C) by adding “and” at the end of subparagraph (E); and

(D) by adding at the end the following new subparagraph:

“(F) with respect to services described in section 1832(a)(2)(J)(i), the amount determined under subparagraph (B), except that ‘100 percent’ shall be substituted for any reference in such subparagraph to ‘80 percent’.”.

(7) CONFORMING AMENDMENTS.—(A) Section 1861(ff) (42 U.S.C. 1395x(ff)) is amended—

(i) in the heading, by striking “Partial Hospitalization” and inserting “Intensive Community-Based”; and

(ii) in paragraph (1), by striking “partial hospitalization” and inserting “intensive community-based”.

(B) Section 1866(e)(2) (42 U.S.C. 1395cc(e)(2)) is amended by striking “partial hospitalization” and inserting “intensive community-based”.

(e) REQUIREMENT FOR PROVISION OF SERVICES THROUGH ORGANIZED SYSTEMS OF CARE FOR AT-RISK CHILDREN.—

(1) REQUIRING COORDINATION OF MENTAL HEALTH SERVICES THROUGH ORGANIZED SYSTEMS OF CARE.—

(A) PSYCHIATRIC HOSPITAL SERVICES.—Section 1812(a)(5) (42 U.S.C. 1395d(a)(5)), as added by subsection (a)(1), is amended by striking the period at the end and inserting the following: “, but only if (with respect to services furnished to an at-risk child described in section 1861(rr)) such services are furnished in conformity with the plan of an organized system of care for mental health and substance abuse services in accordance with section 1861(rr).”.

(B) OTHER PART B ITEMS AND SERVICES.—Section 1862(a)(18), as added by subsection (c)(2), is amended by striking the period at the end and inserting the following: “, and, in the case of services furnished to an at-risk child described in section 1861(rr) who is not an inpatient of a hospital, if the services are not furnished in conformity with the plan of an organized system of care for mental health and substance abuse services in accordance with section 1861(rr).”.

(C) INTENSIVE RESIDENTIAL SERVICES.—Section 1861(qq) (42 U.S.C. 1395x(qq)) as added by subsection (b)(2), is amended—

(i) in paragraph (1), by striking “paragraph (2)” and inserting “paragraphs (2) and (3)”;

(ii) by adding at the end the following new paragraph:

“(3) In the case of services furnished to an at-risk child described in section 1861(rr), no service may be treated as an intensive residential service under this subsection unless the service is furnished in conformity with the plan of an organized system of care for mental health and substance abuse services in accordance with section 1861(rr).”.

(D) INTENSIVE COMMUNITY-BASED SERVICES.—Section 1861(ff)(1) (42 U.S.C. 1395x(ff)(1)) is amended by inserting after “by a physician” the following: “(or, in the case of services furnished to an at-risk child described in section 1861(rr), by an organized system of care for mental health and substance abuse services in accordance with such section)”.

(2) ORGANIZED SYSTEMS OF CARE DESCRIBED.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

“Organized System of Care for Mental Health and Substance Abuse Services

“(rr)(1) The term ‘organized system of care for mental health and substance abuse services’ means, with respect to mental health services provided to an at-risk child, a community-based service delivery network consisting of public or private providers that a State determines meets the following requirements (in accordance with guidelines of the Secretary):

“(A) The system has established linkages with existing mental illness and substance abuse service delivery programs in the area in which the child resides (or is in the process of developing or operating a system with appropriate public agencies in the area to coordinate the delivery of such services to individuals in the area).

“(B) The system provides for the participation and coordination of multiple agencies and providers that serve the needs of children in the area, including agencies and providers involved with child welfare, education, juvenile or criminal justice, health care, mental health, and substance abuse treatment.

“(C) The system provides for the involvement of the families of children to whom mental illness and substance abuse services are provided in the planning of treatment and the delivery of services.

“(D) The system provides for the development and implementation by multidisciplinary and multi-agency teams of individualized treatment plans that are recognized and followed by the requisite providers in the area.

“(E) The system ensures the delivery and coordination of the range of mental illness and substance abuse services required for at-risk children.

“(F) The system provides for the management of the individualized treatment plans and for a flexible response to treatment changes over time.

“(G) The system places individuals in treatment programs in accordance with uniform patient placement criteria established by the Secretary in consultation with the States.

“(2) In this subsection—

“(A) the term ‘at-risk child’ means an individual under 19 years of age who has a serious emotional disorder or substance abuse disorder (in accordance with criteria established by the Secretary for purposes of this subsection) and is currently involved or at imminent risk of being involved with one or more public agencies providing services to children, including agencies relating to child welfare, special education, and juvenile or criminal justice; and

“(B) the term ‘mental health services’ has the meaning given such term in section 1893(c).”

(3) ESTABLISHMENT OF CRITERIA FOR SEVERITY OF ILLNESS BY SECRETARY.—Not later 1 year after the date of the enactment of this Act, the Secretary shall develop criteria for determining whether an individual has a serious emotional disorder or substance abuse disorder for purposes of section 1861(rr)(2).

(f) SPECIAL RULE FOR BENEFICIARIES IN STATES WITH MANAGED PROGRAMS.—Title XVIII is amended by inserting after section 1892 the following new section:

“COVERAGE OF MENTAL HEALTH SERVICES FOR INDIVIDUALS IN STATES WITH MANAGED MENTAL HEALTH PROGRAMS

“SEC. 1893. (a) APPLICATION OF STATE COVERAGE RULES.—Notwithstanding any other provision of this title, in the case of an individual entitled to benefits under part A or enrolled under part B who is a resident of a State operating a comprehensive managed mental health program under section 4201 of the Health Security Act and who is enrolled in the program during a month—

“(1) the individual is considered to have waived the right to benefits for mental health services under this title in consideration of receipt of benefits for mental health services through such program;

“(2) the Secretary shall make a per capita payment to the State, in the amount specified in subsection (b)(1), on behalf of the individual; and

“(3) no other payment may be made under this title with respect to mental health services furnished to the individual during the month.

Payments under paragraph (2) shall be made on a monthly basis.

“(b) AMOUNT OF CAPITATION PAYMENT.—

“(1) IN GENERAL.—In the case of a State operating a program described in subsection (a) for a month, the amount specified in this subsection is the Secretary’s estimate of the sum of the following products:

“(A) The product of—

“(i) the part A per enrollee mental health payment described in paragraph (2) for the month; and

“(ii) the number of individuals in the State who are entitled to benefits under part A during the month and (as estimated prior to the month based on information provided by the State) who are enrolled in the program described in subsection (a).

“(B) The product of—

“(i) the part B per enrollee mental health payment described in paragraph (2) for the month; and

“(ii) the number of individuals in the State who are enrolled under part B during the month and (as estimated prior to the month based on information provided by the State) who are enrolled in the program described in subsection (a).

“(2) PER ENROLLEE PAYMENTS.—In paragraph (1)—

“(A) the ‘part A per enrollee payment’ for a month is an amount equal to the Secretary’s estimate of the average actuarial value of the mental health services for which payment would be made under part A for the month on behalf of individuals enrolled in the State program described in subsection (a) during the month if the individuals were not enrolled in the State program during the month; and

“(B) the ‘part B per enrollee payment’ for a month is an amount equal to the Secretary’s estimate of the average actuarial value of the mental health services for which payment would be made under part B for the month on behalf of individuals enrolled in the State program described in subsection (a) during the month if the individuals were not enrolled in the State program during the month.

“(3) ADJUSTMENTS.—The Secretary shall adjust the amount of payment otherwise made to a State under this subsection for a month—

“(A) to reduce such payment to take into account any amounts paid to the State under other programs (including programs under part A or part E of title IV or under the Individuals With Disabilities Education Act) towards the costs of providing mental health services to individuals enrolled in the program; and

“(B) to take into account overpayments or underpayments made under this subsection in previous months.

“(c) MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES DESCRIBED.—In this section, the term ‘mental health and substance abuse services’ means the following items and services:

“(1) Inpatient psychiatric services (as described in section 1812(a)(5).

“(2) Any items or services furnished under part B for the treatment of mental illness or substance abuse for an individual who is not an inpatient of a hospital.

“(3) Intensive community-based mental health services (as described in section 1861(ff)).

“(4) Intensive residential services (as described in section 1861(qq)).”.

SEC. 3117. EXPANDED COVERAGE OF CERTAIN CHIROPRACTIC SERVICES.

Section 1861(r)(5) (42 U.S.C. 1395x(r)(5)) is amended by striking “sections 1861(s)(1) and 1861(s)(2)(A)” and inserting “paragraphs (1), (2)(A), (3), and (4) of subsection (s)”.

SEC. 3118. MANAGED CARE OPTIONS.

Section 1876(g) (42 U.S.C. 1395mm(g)) is amended by adding at the end the following new paragraph:

“(7) An eligible organization with a risk-sharing contract under this section may provide services under part A and B to individuals enrolled with the organization through an unlimited-choice-of-provider plan described in section 2204(15), except that in no case could the cost sharing requirements imposed under such option with respect to services furnished through providers who are not members of the organization’s provider network (as defined in section 2204(10)) exceed the cost-sharing requirements that would otherwise be imposed with respect to the services if the services were furnished under this title other than through the eligible organization.”.

SEC. 3119. EFFECTIVE DATE.

The amendments made by this part shall apply to items and services furnished on or after January 1, 1998.

TITLE IV—STATE PROGRAMS

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Subtitle A—State Provider Reimbursement Systems

SEC. 4001. STANDARDS FOR STATE PROVIDER REIMBURSEMENT SYSTEMS.

(a) IN GENERAL.—During the period in which a State provider reimbursement system (in this subtitle referred to as a “State system”) is approved under this section—

(1) the payment rates provided under such system shall apply to services covered under the system and furnished in the State;

(2) maximum payment rates shall not apply to such services under subtitle D of title VI, in accordance with section 6621(b)(2)(A); and

(3) the Secretary is deemed to have approved a waiver of such requirements relating to the determination of payment amounts under the medicare program, medicare part C, and medicaid programs as may be necessary to implement such system.

(b) APPLICATION.—Subject to subsection (e), the Secretary may not approve a State system under this section unless the State submits to the Secretary an application in such form and manner and containing such information and assurances (consistent with this subtitle) as the Secretary may require.

(c) CONDITIONS FOR APPROVAL.—

(1) IN GENERAL.—The Secretary shall approve the application of a State with respect to a State system only if the Secretary determines that the conditions for approval described in sections 4002 and 4003 are met.

(2) LIMITATION ON DISAPPROVAL.—The Secretary cannot deny the application of a State for a State system on the ground that the methodology used under the system to control payments for inpatient hospital services is based on a payment methodology other than on the basis of a diagnosis-related group.

(d) TERMINATION OF APPROVAL.—

(1) IN GENERAL.—The Secretary shall terminate approval of a State system in accordance with section 4004 if—

(A) the Secretary determines that the system no longer meets the requirements of section 4002(b)(1) (relating to all payers), section 4002(b)(3)(B) (relating to limitation on differentials for medicaid services), or section 4002(e) (relating to certain requirements for hospitals); or

(B) the Secretary has reason to believe that the assurances described in any of the following sections are not being (or will not be) met:

(i) Section 4002(b)(2) (relating to equitable treatment of all payers).

(ii) Section 4002(f) (relating to special requirements for hospital admissions and exclusions).

(iii) Section 4003 (relating to limiting aggregate expenditures).

(2) ADDITIONAL AUTHORITY.—The Secretary may terminate such approval if the Secretary determines that the system no longer continues to meet another conditions for approval described in section 4002 or 4003.

(e) DEEMED APPROVAL OF CERTAIN SYSTEMS.—

(1) IN GENERAL.—In the case of a hospital reimbursement control system approved under section 1886(c)(4) of the Social Security Act or described in section 1814(b)(3) of such Act and used for payment of hospital services in the State under the medicare program, the system is deemed to be a State system approved under this section with respect to payment for hospital services.

(2) TERMINATION.—Insofar as paragraph (1) applies to a State system, the continuation of the approval of the system is conditioned only upon the system's compliance with the requirements described in such paragraph.

SEC. 4002. GENERAL CONDITIONS FOR STATE PROVIDER REQUIREMENTS FOR STATE SYSTEMS.

(a) APPLICATION TO SERVICES.—

(1) IN GENERAL.—Subject to paragraph (2), the State system applies to services described in any (or all) of the following subparagraphs:

(A) Inpatient hospital services (including services of exempt hospitals (as defined in section 6311(a)(4)) statewide.

(B) Outpatient hospital services (including services of exempt hospitals (as so defined)) statewide.

(C) Physicians services statewide.

For purposes of this part, services described in each of subparagraphs (A), (B), and (C) shall be treated as a separate class of services.

(2) ADDITIONAL SERVICES ONLY BY CLASS OF SERVICE.—The system may apply to services in addition to services described in paragraph (1) only if the system applies to all services within the class (established under section 6002) in which the services are classified.

(b) APPLICATION TO ALL PAYERS; EQUITABLE TREATMENT.—

(1) APPLICATION TO ALL PAYERS.—The system applies to substantially all payers (including the medicare program, medicare part C, and the medicaid program in the State) for services to which the system applies.

(2) EQUITABLE TREATMENT.—The Secretary has been provided satisfactory assurances as to the equitable treatment of all payers (including the medicare pro-

gram, medicare part C, and medicaid programs and other Federal and State programs) under the system.

(3) PAYMENT RATE DIFFERENTIALS PERMITTED.—

(A) IN GENERAL.—Subject to subparagraph (B), a State may provide for payment rates for services furnished under the medicaid program that are different from the payment rates for services for which payment is made by other payers.

(B) LIMITATION ON DIFFERENTIALS FOR SERVICES UNDER MEDICAID.—The ratio of the average rate of payment for services under the medicaid program to such average rate of payment for the same services by health benefit plans (other than the medicare program, medicare part C, and medicaid programs) may not be less than the ratio of the average of the rates of payment within the class of services for which payment is provided under the medicaid program to such average rate of payment under other health benefit plans (other than the medicare program, medicare part C, and medicaid programs) during the most recent year before the implementation of the State system, as determined by the Secretary.

(4) SEPARATE RATE NEGOTIATIONS PERMITTED FOR HEALTH MAINTENANCE ORGANIZATIONS.—

(A) IN GENERAL.—A State may provide that a health maintenance organization (as defined in subparagraph (B)) may negotiate directly with providers of services covered under the system with respect to the organization's rate of payment for such services.

(B) DEFINITION.—In subparagraph (A), the term "health maintenance organization" means an eligible organization with a contract under section 1876 of the Social Security Act or a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act).

(5) MINIMUM PAYMENT RATES.—Under the State system, the State may provide that the amount of payment for any service within a class of services under the system may not be less than a minimum payment rate established by the State for the services.

(c) OPERATION.—The system is operated directly by the State or by a State agency or other public authority. The previous sentence shall be construed to prohibit a State from contracting with private organizations to carry out the requirements of the State system.

(d) REPORTS REQUIRED.—Providers of services covered under the system must make such reports as the Secretary may require in order to monitor assurances provided under section 4003 and make determinations under section 4004.

(e) ASSURANCES OF CONTINUED ACCESS.—The State must provide the Secretary with satisfactory assurances that operation of the system will not result in any change in hospital admission practices or the provision of other services which result in—

(1) a significant reduction in the proportion of patients (receiving services covered under the system) who have no third-party coverage and who are unable to pay for such services,

(2) a significant reduction in the proportion of individuals provided services for which payment is (or is likely to be) less than the anticipated charges or costs of such services, or

(3) the refusal to provide services to individuals who would be expected to require unusually costly or prolonged treatment for reasons other than those related to the appropriateness of the care available from the provider.

(f) SPECIAL REQUIREMENTS FOR HOSPITAL ADMISSIONS AND EXCLUSIONS.—If the system applies to payment for hospital services, the system requires hospitals to which the system applies to meet the requirement of section 1866(a)(1)(G) of the Social Security Act with respect to the medicare program and the system provides for the exclusion of certain costs in accordance with section 1862(a)(14) of such Act (except for such waivers thereof as the Secretary provides by regulation).

SEC. 4003. CONTROL OF AGGREGATE EXPENDITURES REQUIREMENT FOR STATE SYSTEMS.

(a) ASSURANCES REQUIRED.—

(1) IN GENERAL.—A State system may not be approved until the Secretary has been provided satisfactory assurances that under the system, during a 3-year period (the first such period beginning with the first month in which this section applies to that system in the State) the following 2 tests are met:

(A) AGGREGATE EXPENDITURE TEST.—The sum of—

(i) aggregate private sector expenditures (as defined in paragraph (4)), and

(ii) the aggregate medicare expenditures (as defined in paragraph (5)) for such class (or classes) under the system, will not exceed the applicable total limit specified in paragraph (2).

(B) **MEDICARE EXPENDITURE TEST.**—The aggregate medicare expenditures for such class (or classes) under the system will not exceed the applicable medicare limit specified in paragraph (3).

(2) **APPLICABLE TOTAL LIMIT.**—The applicable total limit specified in this paragraph is the total of the maximum amount of payments that would be payable in the State for the covered class (or classes) of services if the State system were not in effect. With respect to payments for individuals who are not enrolled under the medicare program or medicare part C, such amount shall be based on the State private per capita expenditure estimate (established under subtitle B of title VI) for the State, adjusted—

(A) to remove the effect of the adjustment described in section 6101(b)(3), and

(B) to take into account only the proportion of such estimate that is attributable to the covered class (or classes).

(3) **APPLICABLE MEDICARE LIMIT.**—The applicable medicare limit specified in this paragraph is the sum of—

(A) the maximum amount of payments that would be payable in the State for the covered class (or classes) of services under the medicare program if the State system were not in effect, and

(B) the maximum amount of payments that would be payable in the State for the covered class (or classes) of services under medicare part C if the State system were not in effect.

(4) **AGGREGATE PRIVATE SECTOR EXPENDITURES DEFINED.**—In this subtitle, the term “aggregate private sector expenditures” means the product of—

(A) the State private per capita expenditure estimate (referred to in paragraph (2), subject to the adjustment described in such paragraph) for the class (or classes) of services covered under the system, and

(B) the average number of residents of the State enrolled in qualified health plans.

(5) **AGGREGATE MEDICARE EXPENDITURES DEFINED.**—In this subtitle, the term “aggregate medicare expenditures” means expenditures under the medicare program and medicare part C for items and services included in the class (or classes) of services covered under the system.

(6) **WAIVER OF AGGREGATE EXPENDITURE TEST FOR YEARS PRIOR TO 1997.**—The aggregate expenditure test described in paragraph (1) shall not apply with respect to a State system for any year prior to 1997.

(b) **ANNUAL DETERMINATION BY SECRETARY.**—The Secretary shall annually determine whether a State system has met the tests described in subsection (a)(1) for the most recent 3-year period, determined based on all classes of services covered under the system.

(c) **USE OF MEDICARE SAVINGS.**—

(1) **IN GENERAL.**—If the Secretary determines that a State system under this subtitle has resulted in medicare savings over a period of 3 consecutive years, in the 4th year there shall be paid to the State an amount equal to the medicare savings in the first year of such 3-year period. Such payments shall be made from the Federal Hospital Insurance Trust Fund, the Federal Supplementary Medical Insurance Trust Fund, Medicare Part C Trust Fund in such amounts as reflects the medicare savings attributable to the respective Trust Fund in such first year.

(2) **DEFINITIONS.**—In this subsection:

(A) The term “medicare spending” means, with respect to a State in a year, aggregate medicare expenditures incurred under the medicare program and medicare part C in the State in the year.

(B) The term “baseline medicare spending” means, with respect to a State in a year, the amount of aggregate medicare expenditures that the Secretary estimates would have been incurred under the medicare program and medicare part C in the State in the year if this subtitle did not apply in the State.

(C) The term “medicare savings” means, with respect to a State in a year, the amount by which the baseline medicare spending for the State in the year exceeds the medicare spending for the State in the year.

SEC. 4004. TERMINATION OF APPROVAL OF STATE SYSTEM.

(a) **IN GENERAL.**—The Secretary shall terminate approval of a State system in accordance with this section if the Secretary determines under section 4003(b) that the State has not met the tests referred to in such section.

(b) PROCESS.—

(1) **NOTICE.**—The Secretary may terminate the approval of a State system under this subtitle only after the expiration of a 90-day period beginning on the date the Secretary informs the State of the Secretary's intention to terminate such approval, unless, during such 90-day period, the State requests a hearing with the Secretary.

(2) **HEARING.**—If the State requests a hearing during the 90-day period described in paragraph (1), the Secretary shall conduct a hearing during which the State may present evidence showing that the Secretary should not terminate the approval of its system. If the Secretary decides to reject such evidence, the Secretary shall terminate the approval of the State's system beginning with the first day of the first month that begins after the date of the Secretary's decision.

(3) **JUDICIAL REVIEW PROHIBITED.**—There shall be no administrative or judicial review of a decision by the Secretary with respect to the approval (or termination of approval) of a State system under this subsection.

(c) ADJUSTMENTS TO RECAPTURE EXCESS SPENDING.—

(1) **ADJUSTMENT OF MAXIMUM PAYMENT RATES.**—If the Secretary terminates the approval of a State system under this section due to—

(A) a failure to meet the test described in section 4003(a)(1)(A) (relating to aggregate private sector and medicare expenditures), the maximum payment rates otherwise established for services within the class (or classes) of services under subtitle D of title VI shall be adjusted in accordance with paragraph (2)(A), but only for that State; or

(B) a failure to meet the test described in section 4003(a)(1)(B) (relating to aggregate medicare expenditures), the payment rates otherwise established for items and services within the class (or classes) of services under subtitle C of title VIII shall be adjusted in accordance with paragraph (2)(B), but only for that State.

(2) ADJUSTMENTS.—

(A) **IN MAXIMUM PAYMENT RATES FOR PRIVATE SECTOR EXPENDITURES.**—The adjustment described in this subparagraph is such a reduction in the maximum payment rates for the class (or classes) of services covered under the system as the Secretary determines necessary to decrease—

(i) the amount of aggregate private sector expenditures that would otherwise be made for services provided in the State, by

(ii) the amount by which aggregate private sector expenditures for such class (or classes) of services for the 3-year period involved exceeded the applicable private sector limit specified in section 4003(a)(4) for such period.

(B) **IN MEDICARE PAYMENT RATES.**—The adjustment described in this subparagraph for a State is such a reduction in the applicable medicare payment rate for the class (or classes) of services covered under the system as the Secretary determines necessary to decrease—

(i) the amount of aggregate medicare expenditures that would otherwise be made for services provided in the State, by

(ii) the amount by which aggregate medicare expenditures for such class (or classes) of services for the 3-year period involved exceeded the applicable medicare limit specified in section 4003(a)(3) for such period.

(C) **PERIOD OF ADJUSTMENT.**—The adjustments under subparagraphs (A) and (B) shall be made—

(i) during the year following the termination of the system, or

(ii) during each year in the 3-year period following the termination, if the Secretary determines that a reduction over such 3-year period is appropriate in the case of a State.

Subtitle B—State Benefit Management Programs

SEC. 4101. STANDARDS FOR STATE BENEFIT MANAGEMENT PROGRAMS.

(a) **ESTABLISHMENT OF STATE PROGRAMS.**—A State may operate a State benefit management program approved by the Secretary under this subtitle (such a program in this subtitle referred to as a "State program") under which the State—

(1) guarantees coverage for at least the guaranteed national benefit package, including pediatric services for children, for all individuals enrolled in the program; and

(2) controls aggregate health care expenditures in the State (for all classes of services) in the same manner, and subject to the same tests, as a State operating a State provider reimbursement system under subtitle A, without regard to the adjustment described in section 4003(a)(2)(A).

(b) FLEXIBILITY OF PROGRAM.—A State program under this subtitle may provide guaranteed coverage through a State single payer or public plan, an employer mandate, a combination of public and private coverage, competing health plans, managed competition, or any other system, so long as the program covers all eligible individuals who are residents of the State.

(c) CONDITIONS FOR APPROVAL.—The Secretary may not approve a State program under this subtitle unless the Secretary determines that the State and the program meet the applicable requirements of sections 4102 and 4103.

(d) TERMINATION OF APPROVAL.—The Secretary shall terminate approval of a State program in accordance with section 4106 if the Secretary determines that the State or the program no longer meet the applicable requirements of sections 4102 and 4103.

SEC. 4102. GENERAL REQUIREMENTS FOR STATE BENEFIT MANAGEMENT PROGRAMS.

(a) APPLICATION.—The Secretary may not approve a State program under this subtitle unless the State submits to the Secretary an application in such form and manner as the Secretary may require and containing the following information and assurances:

(1) ENSURING ACCESS TO BENEFITS.—Assurances that services under the guaranteed national benefit package will be reasonably accessible to individuals whom the State is required to cover under the program under subsection (b).

(2) PUBLIC ADMINISTRATION.—Assurances that the program will be publicly administered, except that nothing in this paragraph shall be construed to prohibit a State from contracting with private organizations to carry out the requirements of the State program.

(3) SPECIAL REQUIREMENTS FOR PUBLIC PLAN.—To the extent that the State program provides benefits through a plan under which the State makes direct payment to providers for services under the program, assurances that the program—

(A) meets the standards applicable to insured health benefit plans under subtitle A of title V;

(B) provides coverage for emergency and urgent care services furnished to individuals enrolled in the program by out-of-state providers;

(C) has in effect procedures to coordinate the delivery and payment of benefits for individuals enrolled in health benefit plans outside of the State who receive services from providers in the State, individuals who are employees of employers in the State but are not residents of the State, and other individuals for whom coordination of enrollment and delivery and payment of benefits is necessary.

(b) COVERAGE.—

(1) IN GENERAL.—Except as otherwise provided in this subsection and section 4103, the State shall assure that the State program covers all eligible individuals who are residents of the State.

(2) EXCEPTION FOR INDIVIDUALS ENROLLED IN CERTAIN SELF-INSURED HEALTH BENEFIT PLANS.—

(A) IN GENERAL.—A State shall not be considered to have failed to meet the requirement of paragraph (1) with respect to individuals enrolled in a qualified health plan described in subparagraph (B) if the sponsor elects, with respect to all plan enrollees, to provide coverage under the plan and to not participate in the State program.

(B) PLAN DESCRIBED.—A qualified health plan described in this subparagraph is a self-insured health benefit plan (as defined in section 2204(11) of the Social Security Act)—

(i) in the case of a plan sponsored by an employer, that is sponsored by an employer which has full-time employees employed in 2 or more States and has not fewer than 5,000 full-time employees in the United States (as determined in accordance with the criteria described in section 3451(d) of the Internal Revenue Code of 1986); and

(ii) in the case of any other such plan, that has enrollees residing in 2 or more States and has not fewer than 5,000 enrollees in the United States.

(C) PROHIBITING RESTRICTIONS ON ACCESS TO BENEFITS UNDER EXCLUDED PLANS.—A State may not prohibit providers in the State from receiving payment for services provided to individuals enrolled in a plan for which a sponsor makes an election under subparagraph (A) not to participate in the State program, or impose other restrictions on the ability of providers to furnish services to such individuals.

(3) DETERMINATION OF RESIDENCE IN STATE.—

(A) IN GENERAL.—For the purposes of determining eligibility for coverage under a State program, an individual shall be considered a “resident” of the State if the individual lives in the State with the intention of remaining there permanently or indefinitely.

(B) CERTAIN INDIVIDUALS EXCLUDED.—The State may not deny coverage under the State program to an individual described in subparagraph (A) because the individual has not resided in the State for a specified period, or because the individual is temporarily absent from the State, except that a State may deny eligibility for benefits under the program to an individual if the State determines that the individual is residing in the State substantially for the purpose of receiving medical treatment in that State.

(c) ONGOING REPORTS.—A State operating a State program approved by the Secretary under this subtitle shall submit annual reports to the Secretary on the operation of the program, together with such other reports as the Secretary may require.

SEC. 4103. TREATMENT OF MEDICARE BENEFICIARIES.

(a) IN GENERAL.—Except as provided in subsection (b), a State may not cover any individual who is a medicare part A beneficiary or a medicare part C beneficiary under the State program.

(b) PERMITTING STATES TO COVER MEDICARE BENEFICIARIES.—

(1) IN GENERAL.—A State program may cover medicare part A beneficiaries or medicare part C beneficiaries, or both, residing in the State if the State provides such assurances as the Secretary may require that—

(A) all services for which such beneficiaries would otherwise be eligible under the medicare program or medicare part C shall be provided under the State system without additional cost (taking into account section 59B(b) of the Internal Revenue Code of 1986 and subpart 1 of part B of title XXIII of the Social Security Act) to such beneficiaries and shall be reasonably accessible to all such beneficiaries residing in the State; and

(B) such beneficiaries in the State program shall be eligible for the same benefits and provided the same opportunities with respect to choice of health plans as other residents of the State.

(2) TIMING OF COVERAGE.—

(A) MEDICARE PART C BENEFICIARIES.—The coverage of medicare part C beneficiaries under a State program shall begin with the first year for which the State provides evidence, satisfactory to the Secretary, that all of the requirements for the State program will be met, and that all benefits guaranteed to such medicare beneficiaries will be provided, during such year.

(B) MEDICARE PART A BENEFICIARIES.—The coverage of medicare part A beneficiaries shall begin with the first year that occurs after the State program has been in effect for 3 years for which the State provides evidence, satisfactory to the Secretary, that all of the requirements for the State program will be met, and that all benefits guaranteed to such beneficiaries will be provided, during such year.

(3) CONTROL OF MEDICARE EXPENDITURES.—If medicare part A or part C beneficiaries are included in the State program, the State shall guarantee that total expenditures under the medicare program or medicare part C, respectively, in the State during the year will not exceed the expenditures that would otherwise have been made under such program with respect to such beneficiaries residing in the State during the year.

(c) MEDICARE PAYMENT RULES.—In the case of a State program that covers medicare part A or part C beneficiaries, the State shall elect one of the following to apply:

(1) PAYMENT TO BENEFICIARIES AND PROVIDERS BASED ON STATE PAYMENT RATES.—To have the Secretary make payment under the medicare program and medicare part C, respectively, to such beneficiaries or to providers on behalf of such beneficiaries for items and services furnished to such beneficiaries in the same manner as payment is made under such program or part with respect to such beneficiaries who are not covered under a State program, except that such

payment shall be based on the applicable payment rates (and methodology) established under the State program.

(2) **PAYMENT TO STATES BASED ON PROSPECTIVE ESTIMATED EXPENDITURES.**—To have the Secretary make payment directly to the State (on such a periodic basis as the Secretary may establish) for items and services furnished to such beneficiaries, based on the Secretary's prospective estimate of the amounts that would have been paid for such items and services under the medicare program or medicare part C if such the State program did not cover such beneficiaries.

(3) **REIMBURSEMENT OF STATES FOR ACTUAL SERVICES PROVIDED.**—To have the Secretary reimburse the State for payments by the State for items and services covered under the medicare program or medicare part C that are furnished to such beneficiaries directly by the State program, based on the applicable payment rates (and methodology) established under the State program.

(d) **USE OF MEDICARE SAVINGS.**—The provisions of subsection (c) of section 4003 shall apply under this subtitle in the same manner as they apply under subtitle A.

(e) **AUTHORITY TO REDUCE MEDICARE PAYMENTS DURING TRANSITION PERIOD.**—

(1) **IN GENERAL.**—If the Secretary determines at any time during the first 3 years for which a State covers medicare part A beneficiaries or medicare part C beneficiaries under the State program under this subtitle that aggregate medicare expenditures under the medicare program or medicare part C will exceed the applicable medicare limit (for medicare part A or part C beneficiaries, respectively) specified under subparagraph (A) or (B) of section 4003(a)(3), the Secretary may, upon 30 days notice, withhold such an amount from the payments otherwise made on behalf of the medicare program or medicare part C to a State or to health care providers in a State in order to eliminate such excess.

(2) **PROCESS.**—In the case of payments withheld under paragraph (1)—

(A) if the State submits evidence satisfactory to the Secretary that aggregate medicare expenditures in the State do not exceed the applicable medicare limit for the medicare program or medicare part C, the Secretary shall release the payments withheld; or

(B) if the State fails to submit such evidence, the payments withheld shall revert to the medicare program or medicare part C.

(3) **EXCEPTION FOR STATES RECEIVING DIRECT PAYMENTS.**—This subsection shall not apply with respect to a State that elects to receive direct payment from the Secretary with respect to services furnished to medicare beneficiaries under subsection (c)(2).

(f) **REINSTATEMENT OF MEDICARE IN EVENT OF PROGRAM FAILURE TO CONTAIN COSTS OR MEET PROGRAM REQUIREMENTS.**—In the case of a State program which covers medicare part A or part C beneficiaries and fails to meet requirements of this section or of the medicare program or medicare part C, the Secretary shall terminate coverage of such beneficiaries under the State program and make payment for any services covered under the medicare program or medicare part C that were provided to such beneficiaries but were not reimbursed under the State program.

(g) **MEDICARE PART C BENEFICIARY DEFINED.**—In this section, the term "medicare part C beneficiary" means an individual who is enrolled in medicare part C (or who would be enrolled in medicare part C but for enrollment under a State program under this section).

SEC. 4104. OPTIONS RELATING TO PAYMENT FOR PREMIUM SUBSIDIES AND WRAP-AROUND BENEFITS.

(a) **PREMIUM SUBSIDIES.**—

(1) **PREMIUM CERTIFICATE ELIGIBLE INDIVIDUALS.**—

(A) **ELECTION.**—A State with a State program may elect either—

(i) to have payment made directly to the State under section 2324(c)(1)(C)(i) of the Social Security Act in an amount described in subparagraph (B), or

(ii) to continue to have subpart 1 of part B of title XXIII of such Act apply in the State.

(B) **DETERMINATION OF AMOUNT OF PERIODIC PAYMENTS.**—The amount described in this subparagraph is—

(i) in the case of the election described in subparagraph (A)(i), subject to subparagraph (C), with respect to periods occurring during a year the Secretary's estimate of the aggregate amount of the payments that would have been made for premium certificates under subpart 1 of part B of title XXIII of the Social Security Act to individuals covered under the State program during the most recent preceding year if the State did not make the election described in subparagraph (A)(i), increased

by the Secretary's estimate of the rate of increase in the total amount of such payments with respect to such individuals during the year; or
 (ii) in the case of the election described in subparagraph (A)(ii), zero.

(C) SPECIAL RULE FOR PAYMENT TO STATES FOR YEARS BEFORE 1999.—In the case of periods occurring during a year before 1999, the State shall submit to the Secretary such information as the Secretary may require to appropriately estimate the amounts described in subparagraph (B)(i) based on a program established by the State to determine the eligibility of State residents for the premium certificates described in subpart 1 of part B of title XXIII of the Social Security Act (using the same eligibility criteria applicable under such subpart).

(2) TREATMENT OF PART C ELIGIBLE INDIVIDUALS.—

(A) IN GENERAL.—If a State program covers pursuant to section 4013 medicare part C beneficiaries, the Secretary shall make payments to the State under section 2324(c)(1)(C)(iii) of the Social Security Act in the amount described in subparagraph (B).

(B) DETERMINATION OF AMOUNT.—The amount described in this subparagraph is—

(i) in the case of a State program that covers medicare part C beneficiaries, the Secretary's estimate of the aggregate amount of the reduction in the tax imposed under section 59B of the Internal Revenue Code of 1986 that would have resulted from the application of subsection (b) of such section with respect to individuals enrolled in the program during applicable period if the State did not cover such beneficiaries; or

(ii) in the case of a State program that does not cover such beneficiaries, zero.

(C) USE OF DATA.—In computing amounts under this subparagraph (B)(i), the Secretary may use information made available under section 6103(l)(16) of the Internal Revenue Code of 1986.

(3) RECONCILIATION FOR PREVIOUS ERRORS IN ESTIMATION.—The Secretary shall adjust the amount of payment made to the State pursuant to this subsection for periods occurring in a year to take into account any errors in the estimations made in previous payments, based on information furnished by the Secretary of the Treasury and such other information as the Secretary deems necessary.

(b) WRAP-AROUND BENEFITS.—

(1) STATE ELECTION.—A State with a State program under this subtitle may elect either—

(A) to have payment made directly to the State under section 2324(c)(1)(C)(ii) of the Social Security Act in an amount described in paragraph (B), or

(B) to continue to have subpart 2 of part B of title XXIII of such Act apply in the State.

(2) DETERMINATION OF AMOUNT.—The amount described in this subparagraph is—

(A) subject to paragraph (3), in the case of a State program that has made an election described in paragraph (1)(A), the Secretary's estimate of the aggregate amount of the payments that would have been made under subpart 2 of part B of title XXIII of the Social Security Act if such election had not been made; or

(B) in the case of another State program, zero.

(3) SPECIAL RULE FOR PAYMENT TO STATES FOR YEARS PRIOR TO 1999.—In the case of periods occurring during a year prior to 1999, the State shall submit to the Secretary such information as the Secretary may require to appropriately estimate the amounts described in paragraph (2)(A), based on a program established by the State to determine the individuals enrolled in the State program who would be wrap-around eligible individuals but the election under the State program (applying the same criteria and a similar process used by the Secretary to determine whether individuals are wrap-around eligible individuals under subpart 2 of part B of title XXIII of the Social Security Act).

(4) RECONCILIATION FOR PREVIOUS ERRORS IN ESTIMATION.—The Secretary shall adjust the amount of payment made to the State under this subsection for periods occurring in a year to take into account any errors in the estimations made under this subsection.

(5) DEFINITIONS.—In this subsection—

(A) the term "State wrap-around benefits" means a package of benefits consisting of items and services not covered under the guaranteed national benefit package that the Secretary finds is comparable to the wrap-around

benefits provided under subpart 2 of part B of title XXIII of the Social Security Act;

(B) the term "wrap-around benefits" means the benefits described in section 2382 of the Social Security Act (as added by section 8102(a)); and

(C) the term "wrap-around eligible individual" has the meaning given such term in section 2381(b) of the Social Security Act (as added by section 8102(a)).

SEC. 4105. OFFSET TO DIRECT PAYMENTS FOR OUTSTANDING MAINTENANCE OF EFFORT PAYMENTS.

The Secretary shall reduce the amount of any payment made directly to the State under section 4103(c)(2) or subsection (a) or (b)(2) of section 4104 for a period by the amount of any payments owed by the State under part 2 of subtitle B of title VIII for such period.

SEC. 4106. TERMINATION OF APPROVAL.

(a) **ANNUAL DETERMINATION OF BUDGETARY COMPLIANCE BY SECRETARY.**—The Secretary shall annually determine whether a State system has met the tests described in subsection 4102(a)(2) for the most recent 3-year period, determined based on for all classes of services covered under the system.

(b) **PROCESS FOR TERMINATION.**—If the Secretary finds under subsection (a) that the State program approved under this subtitle fails the tests described in section 4102(a)(2), or no longer meets any of the applicable requirements of section 4102 or 4103, the Secretary shall terminate approval of the program, in accordance with the process described in section 4004(b) (relating to termination of a State provider reimbursement system under subtitle A).

Subtitle C—State Comprehensive Managed Mental Health and Substance Abuse Programs

SEC. 4201. STATE COMPREHENSIVE MANAGED MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAMS.

(a) **OPTIONAL ESTABLISHMENT OF PROGRAMS BY STATES.**—A State with an application approved by the Secretary under subsection (b) may establish a comprehensive managed mental health and substance abuse program (in this section referred to as the "Program") under which, during a year the Program is in effect—

(1) the State shall provide (or arrange for the provision of) mental health and substance abuse services through the Program for qualified individuals residing in the State who choose to receive such services through the Program; and

(2) such individuals shall receive such services through the Program and not through a qualified health plan, through the medicare program, or through medicare part C providing the guaranteed national benefit package (except that nothing in this subsection shall be construed to prohibit a State from entering into a contract with such a plan or program under which the State reimburses the plan for providing services under the Program to such individuals).

(b) **ELIGIBILITY REQUIREMENTS FOR STATES.**—A State is eligible to establish a Program under this section if the State submits an application to the Secretary (at such time and in such form as the Secretary may require) containing information and assurances that the State and the Program meets the following requirements:

(1) **COVERAGE OF SERVICES WITHOUT DAY LIMITS.**—The Program provides for coverage of the mental health and substance abuse services described in the guaranteed national benefit package without the imposition of any limits applicable under the package on the number of days for which the services may be provided and (at the option of the State) at a lower coinsurance rate than the rate applicable under the package.

(2) **COVERAGE OF ALL QUALIFIED INDIVIDUALS.**—

(A) **IN GENERAL.**—Except as provided in subparagraph (B), the Program provides for coverage for all qualified individuals in the State (as described in subsection (c)) during the year.

(B) **INITIAL COVERAGE OF ONE GROUP OF QUALIFIED INDIVIDUALS ONLY.**—During any of the first 3 years in which the Program is in operation, the Program may provide for coverage for only the group of qualified individuals described in paragraph (1) of subsection (c) or only the group of qualified individuals described in paragraph (2) of such subsection, except that the Program may not discontinue coverage of any group for which coverage is provided.

(3) **DEVELOPMENT OF INTEGRATED DELIVERY SYSTEMS.**—The Program promotes the development of integrated delivery systems for the management of mental health and substance abuse services for individuals enrolled in the Program.

(4) **ACCESS TO PROVIDERS.**—The State assures that individuals enrolled in the Program have access to the full range of qualified providers necessary to furnish services covered under the Program in accordance with such requirements as the State may impose, except that any individual or entity to whom payment may be made for the provision of mental health and substance abuse services under medicare part C shall be deemed to be a qualified provider under the Program.

(5) **MECHANISM FOR ENROLLMENT OF ADULTS NOT MEETING INCOME ELIGIBILITY REQUIREMENT.**—

(A) **OPTION DESCRIBED.**—A State operating a Program may elect to permit qualified health plans in the State, the medicare program, and medicare part C to enroll in the Program any individual covered under the qualified health plan who would be a qualified individual described in subsection (c)(2) but for the individual's failure to meet the requirement described in subparagraph (E) of such subsection (relating to income).

(B) **REQUIRING ENROLLMENT AND BUY-IN MECHANISM.**—If a State elects to permit plans or programs to enroll individuals in the Program under subparagraph (A), the State shall establish an effective mechanism to enroll such individuals and impose an appropriate premium with respect to such enrollment.

(6) **STANDARDS FOR PROVIDERS OF SUBSTANCE ABUSE SERVICES.**—The State establishes and enforces standards for the eligibility of individuals and entities to furnish substance abuse treatment services under the Program.

(7) **SUBMISSION OF PLAN.**—The State shall submit to the Secretary (and regularly update) a plan describing the operation of the Program, including information on the following:

(A) The management, access and referral structure which the State would use to promote and achieve integration of the services the State intends to integrate under the Program.

(B) The steps to be taken under the Program to ensure the integration of services under the Program with services of other agencies and providers that serve the needs of adults with serious mental illness or substance abuse, or children with serious emotional disturbance or substance abuse (including agencies and providers involved with child welfare, education, juvenile justice, corrections, vocational rehabilitation, crime prevention, health care, mental health, and substance abuse prevention and treatment).

(C) The detailed specifications for the program which will assure that individuals enrolled in the Program have access to each service covered under the Program.

(D) The criteria used by the State to determine whether an individual is a qualified individual under subsection (c).

(E) The involvement of the families of individuals to whom services are provided under the Program in the planning of treatment, the delivery of services, and the evaluation of these interventions.

(F) The application of uniform patient placement criteria (as established by the Secretary in consultation with the States) for determining the placement of individuals enrolled in the Program in treatment programs.

(G) The proposed system for the development and implementation of individualized treatment plans through multi-disciplinary or multi-agency teams.

(H) The description of how the State will provide for public input in the development and ongoing assessment of the Program.

(I) The description of the grievance procedure that will be available to eligible individuals dissatisfied with the Program.

(J) The method and components of Program review, including assessments of clinical outcomes, residential stability, vocational and academic achievement, and management of costs.

(K) The sources of any funds that the State proposes to integrate in order to finance the Program (including funds expended by or provided to the State under title IV of the Social Security Act and under the Individuals With Disabilities Education Act), except that nothing in this section may be construed to permit the State from reducing the level of financial assistance it provides under any other program as a result of receiving funds provided under this Act or amendments made by this Act for the operation of the Program.

(c) **QUALIFIED INDIVIDUALS DESCRIBED.**—In this section, a “qualified individual” is either of the following:

(1) The individual—

(A) is an eligible individual (as defined in section 2);

(B) is under 19 years of age;

(C) has a serious mental illness or emotional disturbance or substance abuse disorder (as determined in accordance with standards established by the Secretary consistent with subsection (d)); and

(D) has such an illness, disturbance, or disorder that is expected to last for not less than 1 year.

(2) The individual—

(A) is an eligible individual;

(B) is 19 years of age or older;

(C) has a serious mental illness or emotional disturbance or substance abuse disorder (as determined in accordance with standards established by the Secretary consistent with subsection (d));

(D) has such an illness, disturbance, or disorder that is expected to last for not less than 1 year; and

(E) has family income not greater than 200 percent of the official poverty line.

(d) **CRITERIA FOR STANDARDS FOR QUALIFIED INDIVIDUALS.**—In establishing standards for purposes of subsection (c), the Secretary shall assure that Programs under this section focus services on adults with serious mental illness, children with serious emotional disturbance, and individuals with substance abuse disorder, as evidenced by a need for multiple services (either a past history, or prediction of future needs), and who have a disorder which is expected to last at least one year.

(e) **MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES DEFINED.**—In this section, the term “mental health and substance abuse services” has the meaning given such term under section 1893(c).

TITLE V—HEALTH PLANS AND HEALTH ALLIANCES

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Subtitle A—Standards for Carriers and Insured Health Benefit Plans

SEC. 5001. ESTABLISHMENT OF FEDERAL STANDARDS.

The Social Security Act (as amended by section 2001) is amended by adding at the end the following new title:

"TITLE XXII—HEALTH BENEFIT PLAN STANDARDS

"PART A—REQUIREMENT FOR CERTIFICATION; ENFORCEMENT; GENERAL PROVISIONS

"SEC. 2201. ESTABLISHMENT OF FEDERAL STANDARDS.

"(a) **ESTABLISHMENT OF GENERAL STANDARDS FOR CARRIERS PROVIDING INSURED HEALTH BENEFIT PLANS.**—Not later than July 1, 1995, the Secretary shall establish standards for carriers providing insured health benefit plans consistent with this section and the requirements described in part B.

"(b) **ROLE OF NAIC IN RELATION TO SOLVENCY STANDARDS.**—

"(1) **REQUEST.**—The Secretary shall request the NAIC within 6 months after the date of the enactment of this title—

"(A) to develop model regulations that specify standards with respect to the solvency requirements described in section 2223, and

"(B) to submit such model regulations to the Secretary.

"(2) **USE OF MODEL REGULATION.**—If the NAIC develops and submits model regulations on a timely basis under paragraph (1) and the Secretary determines that the model regulations incorporates such solvency requirements, the Secretary shall incorporate such model regulations within the standards established under this section.

"(c) **STANDARDS RELATING TO COORDINATION OF ENROLLMENT AND COVERAGE.**—

"(1) **IN GENERAL.**—In establishing standards for health benefit plans under this section, the Secretary shall establish rules concerning when changes in enrollment become effective under health benefit plans in relation to changes in the status of an individual enrolled in a health benefit plan.

“(2) MONTHLY CHANGES.—Such rules shall be designed—

“(A) to provide automatic coverage to newborns as of the date of birth,

“(B) in the case of an individual provided coverage through employment, to provide for coverage through the end of the month in which the employment is terminated, and

“(C) to prevent eligible individuals from having any periods of noncoverage when changing enrollment among health benefit plans.

“(3) SPECIAL RULES FOR COORDINATION OF COVERAGE.—The Secretary shall provide for such standards as may be necessary to provide for the allocation of responsibility among qualified health plans (and the medicare program and medicare part C), as defined in section 2 of the Health Security Act) in the case of an inpatient hospital stay, or in the case in which a single payment amount is made for other services provided over a period of time, that begins during the period of coverage under one such health benefit plan and ends during a period of coverage under another such qualified health plan or program.

“SEC. 2202. REQUIREMENTS FOR CERTIFICATION OF HEALTH BENEFIT PLANS.

“(a) CERTIFICATION OF CARRIERS PROVIDING INSURED HEALTH BENEFIT PLANS.—

“(1) IN GENERAL.—No carrier may sell, issue, or renew a contract under an insured health benefit plan (as defined in section 2204) with respect to an individual or employer in a State unless the carrier, in relation to the plan, and the plan have been certified as meeting the applicable standards established under section 2201—

“(A) by a State regulatory program of the State (approved under subsection (b)), or

“(B) in the case of a State without such an approved program, by the Secretary (in accordance with such procedures as the Secretary establishes).

“(2) PLAN DISAPPROVED.—If the applicable regulatory authority determines that a carrier with respect to an insured health benefit plan does not meet the applicable standards of this title on or after the effective date described in subsection (c), the carrier may not provide coverage under the plan to individuals not enrolled as of the date of the determination and may not continue to provide the plan for plan years beginning after the date of such determination until the authority determines that such carrier and plan are in compliance with such standards.

“(b) STATE APPROVED PROGRAMS.—

“(1) IN GENERAL.—If the Secretary determines that a State has in effect an effective regulatory program for the application of the standards established under part B to carriers providing insured health benefit plans, for establishing enrollment periods under section 2213(b), and for providing for collecting and disseminating information under section 2221, the Secretary may approve such program for purposes of certification of carriers and insured health benefit plans under this title.

“(2) ANNUAL REPORTS.—As a condition for the continued approval of such a regulatory program, the State shall report to the Secretary annually such information as the Secretary may require with respect to the performance of the program. Such information shall include a list of the carriers and insured health benefit plans certified under the program, the compliance of such carriers and plans with the standards established under part B, and enforcement actions taken to ensure such compliance.

“(3) PERIODIC SECRETARIAL REVIEW OF STATE REGULATORY PROGRAMS.—The Secretary annually shall review State regulatory programs approved under paragraph (1) to determine if they continue to apply and enforce the standards. If the Secretary initially determines that a State regulatory program no longer is applying and enforcing such standards, the Secretary shall provide the State an opportunity to adopt such a plan of correction that would bring such program into compliance. If the Secretary makes a final determination that the State regulatory program fails to apply and enforce such standards after such an opportunity, the Secretary shall disapprove such program and assume responsibility for certification of all carriers and insured health benefit plans in that State, for establishing enrollment periods under section 2213(b), and for providing for collecting and disseminating information under section 2221.

“(4) GAO AUDITS.—The Comptroller General shall conduct periodic reviews on a sample of State regulatory programs approved under paragraph (1) to determine their compliance with the requirements of such paragraph. The Comptroller General shall report to the Secretary and Congress on the findings of such reviews.

“(c) EFFECTIVE DATE.—

“(1) IN GENERAL.—Subsection (a) shall apply to contracts under insured health benefit plans sold, issued, or renewed on or after January 1, 1997.

“(2) EXCEPTION FOR PLANS OFFERED IN STATES REQUIRING LEGISLATION.—In the case of an insured health benefit plan sold, issued, or renewed in a State which the Secretary identifies, in consultation with the NAIC, as—

“(A) requiring State legislation (other than legislation appropriating funds) in order for carriers and plans to meet the requirements of part B, but

“(B) having a legislature which is not scheduled to meet in 1996 in a legislative session in which such legislation may be considered, the date specified in this subsection is January 1, 1998, or, if earlier, the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1997. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

“(d) PREEMPTION.—No State may enforce any law or regulation that—

“(1) is inconsistent with standards established under—

“(A) section 2214 (relating to prohibition on pre-existing condition exclusions),

“(B) section 2218 (relating to establishment of premiums), and

“(C) section 2224 (relating to utilization review); or

“(2) establishes market sectors that are different from the market sectors established under section 2211.

“SEC. 2203. ENFORCEMENT.

“(a) APPLICATION OF CIVIL MONETARY PENALTIES.—

“(1) IN GENERAL.—Any person who sells or issues a health plan—

“(A) that is not certified in accordance with this part is subject to a civil money penalty not to exceed \$25,000 for each such violation, or

“(B) in violation of the requirements described in any of the following sections is subject to a civil money penalty not to exceed \$10,000 for each such violation:

“(i) NON-DISCRIMINATION.—Section 2212.

“(ii) OPEN ENROLLMENT.—Section 2213.

“(iii) PRE-EXISTING CONDITION EXCLUSIONS.—Section 2214.

“(iv) CONTINUATION OF COVERAGE.—Section 2216.

“(v) MARKETING OF HEALTH PLANS.—Section 2220.

“(vi) ESSENTIAL COMMUNITY PROVIDERS.—Section 2222.

“(2) PROCEDURES FOR IMPOSITION.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under this subsection in the same manner as they apply to a penalty or proceeding under section 1128A.

“(b) WITHHOLDING FEDERAL FINANCIAL ASSISTANCE TO STATES NOT ENFORCING ANTI-DISCRIMINATION REQUIREMENTS.—If the Secretary finds that a State has not adopted and is not enforcing the requirements described in section 2212 (relating to anti-discrimination requirements for carriers providing insured health benefit plans) with respect to insured health benefit plans in the State, the Secretary may—

“(1) withhold Federal financial assistance payments to the State; and

“(2) refer any findings to the Attorney General for further action pursuant to subtitle A of title IX of the Health Security Act.

“SEC. 2204. DEFINITIONS.

“In this title:

“(1) APPLICABLE REGULATORY AUTHORITY.—The term ‘applicable regulatory authority’ means—

“(A) the Secretary, or

“(B) in the case of a State that has assumed responsibility for enforcement of standards under part B pursuant to section 5001(c) of the Health Security Act, the authority of the State that is exercising such responsibility.

“(2) CARRIER.—The term ‘carrier’ means a licensed insurance company, a hospital or medical service corporation (including an existing Blue Cross or Blue Shield organization, within the meaning of section 833(c)(2) of the Internal Revenue Code of 1986), a health maintenance organization, or other entity licensed or certified by a State to provide health insurance or health benefits. The Secretary may issue regulations that provide for affiliated carriers to be treated as a single carrier where appropriate under this title.

“(3) HEALTH BENEFIT PLAN.—

“(A) IN GENERAL.—The term ‘health benefit plan’ means a health plan, other than a plan described in subparagraph (B).

“(B) EXCEPTION.—The term ‘health benefit plan’ does not include any of the following (or any combination thereof):

“(i) Coverage only for accident, dental, vision, disability income, or long-term care insurance, or any combination thereof.

“(ii) Medicare supplemental health insurance.

“(iii) Coverage issued as a supplement to liability insurance.

“(iv) Liability insurance, including general liability insurance and automobile liability insurance.

“(v) Worker’s compensation or similar insurance.

“(vi) Automobile medical-payment insurance.

“(vii) Coverage for a specified disease or illness.

“(viii) A hospital or fixed indemnity policy.

“(ix) Coverage provided exclusively to individuals who are not eligible individuals under the Health Security Act.

“(4) HEALTH PLAN.—The term ‘health plan’ means—

“(A) any contract of health insurance, including any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization group contract, that is provided by a carrier, or

“(B) an employee welfare benefit plan or other arrangement insofar as the plan or arrangement provides health benefits and is funded in a manner other than through the purchase of one or more policies or contracts described in subparagraph (A).

“(5) HIGH DEDUCTIBLE PLAN.—The term ‘high deductible plan’ means an insured health benefit plan (other than a plan that provides services through a provider network) that provides for cost-sharing using the standard cost-sharing schedule under section 2113(a) for which the carrier establishes the deductible in accordance with paragraph (4) of such section.

“(6) INSURED.—The term ‘insured’ means, with respect to a plan, a plan that is provided by a carrier.

“(7) MANAGED CARE PLAN.—The term ‘managed care plan’ means a health benefit plan that provides for services included in the guaranteed national benefit package under the plan (other than services described in subsections (c) and (d) of section 2219) primarily through providers in the provider network of the plan.

“(8) MARKET SECTOR.—The term ‘market sector’ means a market sector described in section 2211(b).

“(8) NAIC.—The term ‘NAIC’ means the National Association of Insurance Commissioners.

“(9) POINT-OF-SERVICE PLAN.—The term ‘point-of-service plan’ means an unlimited-choice-of-provider plan that permits an enrollee to receive benefits through a provider network.

“(10) PROVIDER NETWORK.—The term ‘provider network’ means, with respect to a health plan, providers who have entered into an agreement with the plan under which such providers are obligated to provide items and services covered under the plan to individuals enrolled in the plan subject to the managed care cost-sharing schedule established under section 2113.

“(11) SELF-INSURED.—The term ‘self-insured’ means, with respect to a plan, a plan that is described in paragraph (4)(B).

“(12) SPONSOR.—The term ‘sponsor’ means, in relation to a health plan that—

“(A) is an insured, the carrier providing the plan, or

“(B) is a self-insured, the entity that sponsors the plan (as defined by the Secretary).

“(13) STATE.—The term ‘State’ means the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

“(14) TYPE OF PLAN.—Each of the following is considered to be a separate “type” of plan:

“(A) A managed care plan.

“(B) A point-of-service plan.

“(C) A high deductible plan.

“(D) An unlimited-choice-of-provider plan that is not a point-of-service plan or a high deductible plan.

“(15) UNLIMITED-CHOICE-OF-PROVIDER PLAN.—

“(A) IN GENERAL.—The term “unlimited-choice-of-provider plan” means a health benefit plan that, regardless of whether it permits enrollees to receive benefits through a provider network—

“(i) provides coverage for all items and services included in the guaranteed national benefit package that are furnished by any lawful health care provider, subject to permissible coverage limitations (described in subparagraph (B)), and

“(ii) makes payment to such a provider whether or not there is a contractual arrangement between the plan and the provider subject to cost sharing at the standard cost-sharing schedule (described in section 2112).

“(B) PERMISSIBLE COVERAGE LIMITATIONS DESCRIBED.—The permissible coverage limitations are (as specified by the Secretary) the following:

“(i) Utilization review.

“(ii) Prior approval for specified services (not including routine prior approval for services), other than services provided for the treatment of an emergency medical condition (as defined in section 1867(e)(1)).

“(iii) Exclusion of providers on the basis of poor quality of care, based on evidence obtainable by the plan.

“PART B—STANDARDS FOR INSURED HEALTH BENEFIT PLANS DESCRIBED

“SEC. 2211. ESTABLISHMENT OF MARKET SECTORS.

“(a) OFFERING OF PLANS WITHIN MARKET SECTORS.—A carrier offering an insured health benefit plan in a State may offer such a plan in one or more of the market sectors described in subsection (b).

“(b) MARKET SECTORS DESCRIBED.—For purposes of this title, each of the following is a separate market sector:

“(1) INDIVIDUAL MARKET SECTOR.—The individual market sector, consisting of individuals seeking coverage on behalf of themselves (and their dependents) and not seeking coverage on the basis of employment or membership in a qualifying organization, or through a health alliance.

“(2) SMALL EMPLOYER MARKET SECTOR.—The small employer market sector, consisting of small employers seeking coverage on behalf of their employees (and dependents) and on behalf of other individuals on the basis of their employment (or similar business relationship) with the employer and not seeking coverage on the basis of membership in a qualifying organization or through a health alliance.

“(3) LARGE EMPLOYER MARKET SECTOR.—The large employer market sector, consisting of large employers seeking coverage on behalf of their employees (and dependents) and on behalf of other individuals on the basis of their employment (or similar business relationship) with the employer and not seeking coverage on the basis of membership in a qualifying organization.

“(4) ASSOCIATION MARKET SECTOR.—The association market sector, consisting of qualifying organizations seeking coverage on behalf of their members (and dependents) other than through a health alliance.

“(5) ALLIANCE MARKET SECTOR.—The alliance market sector, consisting of individuals and small employers seeking coverage through a health alliance.

“(c) DEFINITIONS.—In this section:

“(1) EMPLOYEE INCLUDING SELF-EMPLOYED.—The term ‘employee’ includes, with respect to an employer that is a self-employed individual, the self-employed individual.

“(2) HEALTH ALLIANCE.—The term ‘health alliance’ means an alliance described in section 2261, without regard to whether or not a grant is made under section 2262 for the area in which the alliance is located.

“(3) LARGE EMPLOYER.—The term ‘large employer’ has the meaning given such term in section 3451(d) of the Internal Revenue Code of 1986.

“(4) QUALIFYING ORGANIZATION.—The term ‘qualifying organization’ means an association, religious fraternal organization, or other organization (which may be a trade, industry, or professional association, a chamber of commerce, or a public entity association) that the Secretary finds—

“(A) has been formed for purposes other than the sale of health insurance and does not restrict membership based on any characteristic described in section 2212(a),

“(B) does not exist solely or principally for the purpose of selling insurance,

“(C) has at least 1,000 individual members or 200 employer members,

“(D) offered a health benefit plan as of December 31, 1993, and

"(E) any health benefit plan it offers to its members is made available consistent with the requirements of section 2212(a).

Such term includes a subsidiary or corporation that is wholly owned by one or more qualifying organizations.

"(5) SMALL EMPLOYER.—The term 'small employer' means an employer that is not a large employer and employees at least 2 employees.

"SEC. 2212. NON-DISCRIMINATION.

"(a) NO DISCRIMINATION BASED ON HEALTH STATUS.—A carrier may not deny, limit, or condition the coverage under (or benefits of) an insured health benefit plan based on the health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability, of an individual.

"(b) OTHER DISCRIMINATION PROHIBITED.—A carrier may not engage in any activity in relation to an insured health benefit plan offered in a market sector that directly or indirectly would have the effect of discriminating against an individual on the basis of race, national origin, religion, gender, sexual orientation, language, socio-economic status, age, health status, or anticipated need for health services.

"SEC. 2213. OPEN ENROLLMENT.

"(a) IN GENERAL.—Subject to the succeeding provisions of this section, a carrier that offers an insured health benefit plan in a market sector to individuals residing (or to employers or associations located) in a State must offer the same plan to any other resident of (or employer or association located in) the State who is eligible to seek coverage through such a sector.

"(b) ENROLLMENT PERIODS.—

"(1) IN GENERAL.—Except as provided under paragraph (2), the requirement described in subsection (a) shall apply on a continuous, year-round basis.

"(2) ENROLLMENT FOR PLANS IN INDIVIDUAL MARKET SECTOR.—With respect to the individual market sector (as described in section 2211(b)(1)) in a State, the following rules apply:

"(A) ANNUAL OPEN ENROLLMENT PERIOD.—The State shall establish an annual open enrollment period of at least 45 days during which a carrier may not refuse to enroll an eligible individual who seeks coverage in the individual market sector. Before and during each such open enrollment period, the carrier shall advertise the availability of coverage in the individual market sector.

"(B) CONTINUOUS OPEN ENROLLMENT FOR NEW MARKET ENTRANTS.—A carrier may not refuse to enroll an eligible individual who is not enrolled in an insured health benefit plan offered in the individual market sector.

"(C) PERMITTING CHANGE IN PLAN DURING 1ST YEAR OF COVERAGE.—In the case of an individual during the individual's first year of coverage under an insured health benefit plan offered in the individual market sector, the individual may change the plan under which the individual is provided coverage. Such a change shall be effective on the first day of the first month beginning at least 45 days after the date the individual provides notice to the carrier offering the plan in which the individual seeks coverage.

"(D) PERMITTING CONTINUOUS OPEN ENROLLMENT.—Nothing in this subparagraph may be construed to prohibit a carrier from permitting enrollment of any individual at any other time, so long as the carrier permits enrollment of any individual eligible to enroll and does not discriminate among such individuals in violation of section 2212.

"(3) EXCEPTION FOR INDIVIDUAL AND SMALL EMPLOYER MARKET SECTORS FOR YEARS BEFORE 1998.—

"(A) INDIVIDUAL MARKET SECTOR.—During any year prior to 1998, a carrier may refuse to enroll an individual in an insured health benefit plan offered in the individual market sector, except during an annual 30-day open enrollment period established by the State for all carriers in the State during which the plan would be required to provide for enrollment of any eligible individual. Before and during such open enrollment period, the carrier shall advertise the availability of coverage under such plans.

"(B) SMALL EMPLOYER MARKET SECTOR.—During any year prior to 1998, a carrier may refuse to provide coverage with respect to a small employer through the small employer market sector if the employer does not meet standards of the carrier relating to the minimum participation of employees of the employer in insured health benefit plans offered through such sector (in accordance with standards established by the Secretary), except during an annual 30-day open enrollment period established by the State for all carriers in the State during which the plan would be required to provide for coverage with respect to any small employer. Prior to and during such

open enrollment period, the carrier shall advertise the availability of coverage under such plans.

“(4) EXCEPTION FOR TERMINATED PLANS.—A carrier may refuse to enroll an individual in an insured health benefit plan offered in a market sector if the carrier is terminating enrollment in the plan pursuant to section 2216(c).

“(c) CARRIERS THAT ARE QUALIFYING ORGANIZATIONS.—In the case of a qualifying organization (as defined in section 2211(c)(3)) that is a carrier and that was a carrier as of December 31, 1993, the organization may limit enrollment in health plans it offers as a carrier to members of the organization.

“(d) TREATMENT OF MANAGED CARE PLANS.—A carrier providing a managed care plan may apply to the applicable regulatory authority to cease enrolling new employers or individuals in part or all of the service area of the plan if it can demonstrate that its financial or administrative capacity to serve previously enrolled employers and individuals (and additional individuals who will be expected to enroll because of affiliation with such previously enrolled employers) will be impaired if it is required to enroll new employers or individuals.

“SEC. 2214. PROHIBITION ON PRE-EXISTING CONDITION EXCLUSIONS.

“(a) IN GENERAL.—A carrier may not exclude or limit coverage under an insured health benefit plan with respect to services covered under the plan related to treatment of a pre-existing condition.

“(b) TRANSITION FOR YEARS PRIOR TO 1998.—

“(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, a carrier providing an insured health benefit plan may exclude coverage with respect to services related to treatment of a pre-existing condition, but the period of such exclusion may not exceed 6 months and such exclusion shall not apply with respect to services furnished to newborns or to a plan for which such exclusion did not apply as of the effective date of subtitle D of title V of the Health Security Act.

“(2) CREDITING OF PREVIOUS COVERAGE.—

“(A) IN GENERAL.—A carrier providing an insured health benefit plan shall provide that if an individual covered under such a plan is in a period of continuous coverage (as defined in subparagraph (B)(i)) with respect to particular services as of the date of initial coverage under such plan, any period of exclusion of coverage with respect to a preexisting condition for such services or type of services shall be reduced by 1 month for each month in the period of continuous coverage.

“(B) DEFINITIONS.—As used in this paragraph:

“(i) PERIOD OF CONTINUOUS COVERAGE.—The term ‘period of continuous coverage’ means, with respect to particular services, the period beginning on the date an individual is enrolled under a health benefit plan, the medicare program, a State medicaid plan, or other health benefit arrangement which provides benefits with respect to the same or substantially similar services (as determined in accordance with criteria established by the Secretary) and ends on the date the individual is not so enrolled for a continuous period of more than 3 months.

“(ii) PREEXISTING CONDITION.—The term ‘preexisting condition’ means, with respect to coverage under a health benefit plan, a condition which has been diagnosed or treated during the 6-month period ending on the day before the first date of such coverage (without regard to any waiting period).

“SEC. 2215. PROHIBITION AGAINST WAITING PERIODS.

“(a) IN GENERAL.—Except as otherwise provided in this section, a carrier shall provide coverage of an individual under an insured health benefit plan as of the first day of the month following the month of enrollment. A carrier may not impose any waiting period on an enrollee before providing coverage under an insured health benefit plan.

“(b) COVERAGE AFTER ENROLLMENT DURING ANNUAL OPEN ENROLLMENT PERIOD.—In the case of an individual who enrolls in an insured health benefit plan during an open enrollment period described in section 2213(b)(2)(A) or section 2213(b)(3), the carrier shall provide coverage of the individual under the plan effective as of such date as the State may establish with respect to enrollments made during such period (consistent with the standards established by the Secretary under section 2201(c)).

"SEC. 2216. CONTINUATION OF COVERAGE REQUIREMENTS.

"(a) IN GENERAL.—A carrier may not refuse to enroll, refuse to renew the enrollment of, or terminate the enrollment of, an individual or employer in an insured health benefit plan except for—

"(1) nonpayment of premiums, and

"(2) fraud or misrepresentation of material fact.

"(b) TRANSITION FOR NON-CONFORMING POLICIES.—Notwithstanding State law or the provision of any agreement to the contrary, effective January 1, 1998, a carrier may cancel or refuse to renew a health insurance policy issued in a State prior to the application of this part to health benefit plans sold or issued in the State if the policy does not provide for coverage of the guaranteed national benefit package, but only if the carrier offers the policyholder affected the opportunity to obtain coverage under an insured health benefit plan meeting the standards established under this part.

"(c) EXCEPTION FOR PLANS EXITING MARKET.—

"(1) IN GENERAL.—A carrier may refuse to renew the enrollment of, or terminate the enrollment of, an individual or employer in an insured health benefit plan offered in a market sector if—

"(A) the carrier is terminating the enrollment of all individuals in such plan and provides notice to the enrollees and the applicable regulatory authority, or

"(B) the carrier is terminating the plan pursuant to a joint marketing agreement entered into prior to January 1, 1994.

"(2) LIMITATION ON OFFERING OF OTHER PLANS IN MARKET SECTOR.—

(A) IN GENERAL.—Subject to subparagraph (B), if a carrier terminates the enrollment of individuals in a plan offered in a market sector pursuant to paragraph (1) in a State, the carrier may not offer a plan (that is the same type as the type of plan terminated) in the market sector to individuals or employers in the State until the expiration of the 5-year period that begins on the date that no individual is enrolled in the plan in the State.

"(B) PLANS WITH PROVIDER NETWORKS.—In the case of a carrier that offers a managed care plan or a point-of-service plan with a provider network that serves an area smaller than an entire State, subparagraph (A) shall apply with respect to such service area instead of the State.

"SEC. 2217. BENEFIT REQUIREMENTS.

"(a) REQUIRING OFFER OF PLAN CONSISTING OF GUARANTEED NATIONAL BENEFIT PACKAGE.—

"(1) IN GENERAL.—Each carrier that offers an insured health benefit plan shall offer such a plan that only includes coverage for the benefits contained in the guaranteed national benefit package (established under title XXI). A carrier may offer a plan within each type of plan within each market sector.

"(2) LIMITATION ON OFFERING OF HIGH DEDUCTIBLE PLANS.—A carrier may not offer an insured health benefit plan that is a high deductible plan except—

"(A) in the small employer market sector and the large employer market sector, and

"(B) only with respect to an employer who demonstrates that the employer is making contributions to medical savings accounts in accordance with section 3466(d)(2)(C)(i) of the Internal Revenue Code of 1986.

"(b) PREEMPTION OF STATE LAWS REQUIRING PLANS TO COVER ADDITIONAL BENEFITS.—Subsection (a)(1) shall preempt any State law requiring a carrier to include in an insured health benefit plan coverage for any benefit not contained in the guaranteed national benefit package.

"(c) SPECIAL RULE FOR ENROLLEES COVERED UNDER STATE MANAGED MENTAL HEALTH PROGRAMS.—

"(1) PAYMENT TO STATE OF CAPITATED PAYMENT.—In the case of an individual enrolled in an insured health benefit plan who is enrolled in a State managed mental health program approved under section 3201 of the Health Security Act for a month—

"(A) the individual is considered to have waived the right to benefits for mental health services through the plan in consideration of receipt of benefits for mental health services through such program;

"(B) the carrier providing the plan shall make a per capita payment to the State, in the amount specified in paragraph (2), on behalf of the individual; and

"(C) the carrier is not obligated to make any other payment under the plan with respect to mental health services furnished to the individual during the month.

Payments under subparagraph (B) shall be made on a monthly basis.

"(2) CAPITATED PAYMENT AMOUNTS.—The amount of the per capita payment required under paragraph (1) shall be an amount determined in accordance with a methodology established by the Secretary (similar to the methodology used under section 1893(b) to determine capitated payments to States on behalf of medicare beneficiaries enrolled in such State programs) that reflects the portion of the premium associated with the coverage of mental health services under the guaranteed national benefit package that would be provided to the individual under the plan if the individual were not enrolled in the State managed mental health program.

"(3) MENTAL HEALTH SERVICES DESCRIBED.—In this subsection, the term 'mental health services' has the meaning given such term in section 1893(c).

"SEC. 2218. REQUIREMENTS RELATING TO COMMUNITY RATING OF PREMIUMS.

"(a) IN GENERAL.—Subject to subsections (b) and (c), the premium rate charged by a carrier for a type of insured health benefit plan in a community (as specified under subsection (d)) within a market sector (other than the large employer market sector) shall not vary except by class of enrollment in accordance with subsection (e).

"(b) TRANSITION.—

"(1) FIRST YEAR.—In the first year for which this part applies to a carrier in a State, the premium rate charged by the carrier for an insured health benefit plan providing the guaranteed national benefit package in a community may vary within a class of enrollment so long as the premium range percentage (as defined in paragraph (3)) does not exceed $\frac{2}{3}$ of the premium range percentage of premium rates charged by the carrier for insured health benefit plans providing similar benefits in the community in the previous year.

"(2) SECOND YEAR.—In the second year for which this part applies to a carrier in a State, the premium rate charged by the carrier for an insured health benefit plan providing the guaranteed national benefit package in a community may vary within a class of enrollment so long as the premium range percentage does not exceed $\frac{1}{2}$ of the maximum premium range percentage permitted under paragraph (1) for the previous year.

"(3) PREMIUM RANGE PERCENTAGE DEFINED.—In this subsection, the term 'premium range percentage' means—

"(A) the highest premium rate minus the lowest premium rate, divided by

"(B) the lowest premium rate, expressed as a percentage.

"(4) PERMISSIBLE VARIATION.—Section 2212(a) and 2212(b) (insofar as it relates to age, gender, health status, or anticipated need for health services) shall not apply to variations in premiums permitted under this subsection.

"(c) PREMIUMS IN THE ALLIANCE MARKET SECTOR.—

"(1) IN GENERAL.—A carrier that offers an insured health benefit plan in the alliance market sector may charge separate premium rates with respect to individuals and small employers that are eligible for coverage under the individual market sector and under the small employer market sector, respectively, if such rates are otherwise consistent with subsection (a) and paragraph (2).

"(2) RELATION TO INDIVIDUAL AND SMALL EMPLOYER RATES.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), if a carrier offers an insured health benefit plan in the individual or small employer market sector and in the alliance market sector, the premium rates charged by a carrier for an insured health benefit plan offered in the alliance sector to individuals or small employers shall be the same as the premium rates charged by the carrier for such plan offered in the individual market sector or in the small employer market sector, respectively.

"(B) NEGOTIATION OF ADMINISTRATIVE DISCOUNT.—A carrier may reduce the premium rate otherwise charged for an insured health benefit plan offered in the alliance sector to individuals or small employers, or both, by an amount (expressed as a fixed dollar amount or a percentage of the premium otherwise imposed) negotiated with the health alliance involved that reflects only the reduced administrative costs associated with the offering of plans through the alliance and does not relate to differences in anticipated claims, costs, or utilization. Such discount shall not vary among individuals or small employers other than by the class of enrollment involved.

"(d) SPECIFICATION OF COMMUNITY.—

"(1) IN GENERAL.—A carrier may only define a community, for purposes of this section, consistent with this subsection.

"(2) NO SPLITTING OF MSA.—The entire part of a metropolitan statistical area shall be in the same community.

"(3) TREATMENT OF NON-MSA.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), all portions of a State that are outside a metropolitan statistical area shall be in a single community.

"(B) STATE MAY DIVIDE.—A State may divide the portions of a State that are outside a metropolitan statistical area into more than one community, for all carriers in the State.

"(e) CHARGING RATES BY CLASS OF ENROLLMENT.—

"(1) IN GENERAL.—Each carrier shall establish separate premium rates for each of the three classes of enrollment described in section 3(b) of the Health Security Act for each market sector (including the large employer market sector).

"(2) VARIATIONS ONLY BY ACTUARIAL VALUE.—The differences among such rates for an insured health benefit plan shall reflect only differences in the actuarial value of the guaranteed national benefit package among the classes of enrollment, consistent with standards established by the Secretary.

"(f) RISK ADJUSTMENT.—

"(1) DEVELOPMENT OF MODELS BY SECRETARY.—

"(A) IN GENERAL.—The Secretary shall develop one or more model risk adjustment systems under which premiums applicable to insured health plans offered by carriers in a market sector (other than the large employer market sector) would be adjusted to take into account such factors as the Secretary considers appropriate to predict the future need and use of services by individuals enrolled in such plans, which may include—

"(i) the age, gender, geographic residence, health status, socio-economic status, or other demographic characteristics of individuals enrolled in such plans; and

"(ii) the proportion of individuals enrolled in such plans who are AFDC recipients (as defined in section 2(1) of the Health Security Act) or SSI recipients (as defined in section 2(11) of the Health Security Act).

"(B) UPDATING MODELS.—The Secretary may periodically modify the model risk adjustment systems developed under subparagraph (A) as the Secretary considers appropriate.

"(C) ADJUSTMENT FOR PEDIATRIC RISK FACTORS.—In addition to the risk adjustment methodology developed under subparagraph (A), the Secretary shall develop such a model methodology for pediatric risk factors, based on factors that predict solely the future need and use of health services by children enrolled in health benefit plans.

"(2) APPLICATION OF METHODOLOGY TO PLANS.—The State shall require carriers providing insured health plans in the State in a market sector (other than the large employer market sector) to meet the requirements of one of the model risk adjustment systems developed by the Secretary under paragraph (1)(A), or the requirements of an alternative system adopted by the State and approved by the Secretary.

"SEC. 2219. SPECIAL REQUIREMENTS FOR MANAGED CARE AND POINT-OF-SERVICE PLANS.

"(a) IN GENERAL.—The additional requirements of this section shall apply—

"(1) in the case of a managed care plan; and

"(2) with respect to the furnishing of items and services through a provider network of a point-of-service plan.

"(b) ARRANGEMENTS WITH PROVIDERS.—

"(1) IN GENERAL.—The carrier shall enter into such agreements with health care providers (including primary and specialty providers for children) or have such other arrangements as may be necessary to assure that individuals enrolled with the plan through the plan's provider network have reasonably prompt access to all items and services contained in the guaranteed national benefit package (including access to services on a 24-hour basis where medically necessary), in a manner that assures the continuity of the provision of such items and services.

"(2) PROVISION OF PHYSICIANS' SERVICES.—In the case of a managed care plan, the plan provides for coverage of physicians' services primarily—

"(A) directly through physicians who are either employees or partners of the carrier offering the plan; or

"(B) through contracts with individual physicians or one or more groups of physicians (organized on a group practice or individual practice basis).

“(3) ACCESS TO CENTERS OF EXCELLENCE.—

“(A) IN GENERAL.—The carrier shall demonstrate that individuals enrolled in a plan (including individuals with chronic diseases) have access through the plan’s provider network to specialized treatment expertise of designated centers of excellence. The carrier shall demonstrate such access according to standards developed by the Secretary, including requirements relating to plan arrangements with such centers and plan referral of patients to such centers.

“(B) DESIGNATION OF CENTERS OF EXCELLENCE.—The Secretary shall establish a process for the designation of facilities as centers of excellence for purposes of this paragraph. A facility may not be designated unless the facility is determined—

“(i) to provide specialty care,

“(ii) to deliver care for complex cases requiring specialized treatment and for individuals with chronic diseases, and

“(iii) to meet other requirements that may be established by the Secretary relating to specialized education and training of health professionals, participation in peer-reviewed research, or treatment of patients from outside the geographic area of the facility.

“(4) NO REFERRAL REQUIRED FOR OBSTETRICS AND GYNECOLOGY.—A carrier may not require an individual to obtain a referral from a physician in order to obtain covered items and services from a physician who specializes in obstetrics and gynecology.

“(c) PROVISION OF EMERGENCY AND URGENT CARE SERVICES.—

“(1) IN GENERAL.—The plan must cover medically necessary emergency and urgent care services provided to enrollees (including trauma services provided by designated trauma centers), without regard to whether or not the provider furnishing such services has a contractual (or other) arrangement with the plan to provide items or services to enrollees of the plan and, in the case of services furnished for the treatment of an emergency medical condition (as defined in section 1867(e)(1)), without regard to prior authorization.

“(2) DESIGNATED TRAUMA CENTERS DEFINED.—In paragraph (1), the term ‘designated trauma center’—

“(A) has the meaning given such term in section 1231 of the Public Health Service Act, and

“(B) includes (for years prior to 2001) a trauma center that—

“(i) is located in a State that has not designated trauma centers under section 1213 of such Act, and

“(ii) the Secretary finds meets the standards under such section to be a designated trauma center.

“(d) REQUIRING COVERAGE OF OUT-OF-NETWORK SERVICES BY MANAGED CARE PLANS.—Each managed care plan shall provide coverage for items and services, covered under the guaranteed national benefit package, if provided by a provider who is not a member of the plan’s provider network. Such coverage shall be subject to the cost-sharing schedule established under section 2114(d).

“(e) STANDARDS RELATING TO PROVIDER NETWORKS.—

“(1) LIMITATIONS ON ABILITY TO EXCLUDE PROVIDERS FROM NETWORK.—

“(A) IN GENERAL.—Except as provided in subparagraph (C), a carrier of an insured health plan may not exclude from the provider network of the plan any provider of covered items or services who is willing to accept the terms for participation in the network, including terms relating to the schedule of fees, covered expenses, and quality standards.

“(B) CONSTRUCTION.—Nothing in this section may be construed to prohibit a carrier from carrying out any of the following activities with respect to providers who are members of a plan’s provider network:

“(i) Instituting criteria for the credentialing of providers.

“(ii) Requiring providers to accept discounts in fees.

“(iii) Matching the availability of providers with the needs of individuals enrolled in the plan.

“(iv) Establishing measures to maintain quality and control costs.

“(C) EXCEPTION FOR DEDICATED GROUP AND STAFF MODEL HEALTH MAINTENANCE ORGANIZATIONS.—Subparagraph (A) shall not apply with respect to a managed care plan that is a health maintenance organization if the organization—

“(i) is treated as described in section 501(c)(3) of the Internal Revenue Code of 1986 pursuant to section 501(n)(2) of such Code, or

“(ii) is not so treated but substantially all of its primary care health services are provided by the organization to its members at its own fa-

cilities through health care professionals who do not provide substantial health care services other than on behalf of such organization.

“(2) DUE PROCESS PROTECTIONS FOR PROVIDERS.—

“(A) STANDARDS FOR SELECTION OF PROVIDERS FOR NETWORK.—

“(i) ESTABLISHMENT.—The carrier shall establish standards to be used by the carrier for contracting with health care providers with respect to the plan’s provider network. Such standards shall be established in consultation with providers who are members of the network.

“(ii) DISTRIBUTION OF INFORMATION.—Descriptive information regarding these standards shall be made available to enrollees, providers who are members of the network, and prospective enrollees and prospective participating providers.

“(B) NOTICE REQUIREMENT.—

“(i) IN GENERAL.—The carrier may not terminate or refuse to renew an agreement with a provider to participate in the plan’s provider network unless the carrier provides written notification to the provider of the carrier’s decision to terminate or refuse to renew the agreement. The notification shall include a statement of the reasons for the carrier’s decision, consistent with the standards established under subparagraph (A).

“(ii) TIMING OF NOTIFICATION.—The carrier shall provide the notification required under clause (i) at least 45 days prior to the effective date of the termination or expiration of the agreement (whichever is applicable). The previous sentence shall not apply if failure to terminate the agreement prior to the deadline would adversely affect the health or safety of an individual enrolled with the plan.

“(C) REVIEW PROCESS.—

“(i) IN GENERAL.—The carrier shall provide a process under which the provider may request a review of the carrier’s decision to terminate or refuse to renew the provider’s participation agreement. Such review shall be conducted by a group of individuals the majority of whom are health care providers who are members of the plan’s provider network or employees of the carrier, and who are members of the same profession as the provider who requests the review.

“(ii) COUNSEL.—If the provider requests in advance, the carrier shall permit an attorney representing the provider to be present at the provider’s review.

“(iii) REVIEW ADVISORY.—The findings and conclusions of a review under this subparagraph shall be advisory and non-binding.

“(D) CONSTRUCTION.—Nothing in this paragraph shall be construed to affect any other provision of law that provides an appeals process or other form of relief to a provider of health care services.

“SEC. 2220. STANDARDS FOR MARKETING OF HEALTH BENEFIT PLANS.

“(a) MARKETING RESTRICTIONS ON CARRIERS.—

“(1) IN GENERAL.—Each carrier—

“(A) shall file any marketing materials for insured health benefit plans it provides for approval by the applicable regulatory authority prior to distributing them within the plan’s service area; and

“(B) may not distribute any such materials that have not been previously approved by such authority.

“(2) RESTRICTION ON USE OF MARKETING MATERIALS.—All such approved marketing materials—

“(A) shall be made available uniformly throughout the State, and

“(B) may not be used to attract or limit enrollment of certain individuals or groups on the basis of personal characteristics or anticipated need for health services.

“(b) NONDISCRIMINATION IN AGENT COMPENSATION.—A carrier—

“(1) may not vary or condition the compensation provided to an agent or broker related to the sale or renewal of an insured health benefit plan because of the health status or claims experience of any individuals enrolled with the carrier through the agent or broker; and

“(2) may not terminate, fail to renew, or limit its contract or agreement of representation with an agent or broker for any reason related to the health status or claims experience of any individuals enrolled with the carrier through the agent or broker.

“(c) CONSTRUCTION.—Nothing in this part may be construed to permit a State or a health alliance to restrict the ability of a carrier to contract with an agent or broker for the sale of an insured health plan offered by the carrier.

“SEC. 2221. COLLECTION AND DISSEMINATION OF PLAN INFORMATION.

“(a) PROVISION OF INFORMATION BY CARRIERS.—A carrier providing an insured health benefit plan in a State shall provide to the applicable regulatory authority information requested by the State to disseminate information under this section.

“(b) ANNUAL INFORMATION ON INSURED HEALTH BENEFIT PLANS.—

“(1) IN GENERAL.—Each applicable regulatory authority in a State shall annually prepare and make available to consumers, in a uniform format, information on insured health benefit plans sold in the State.

“(2) INFORMATION DESCRIBED.—Such information shall include summary information—

“(A) for each plan, on—

“(i) the premium for the plan,

“(ii) identity, location, qualifications and availability of providers in any provider networks of the plan,

“(iii) the number of individuals enrolling and disenrolling from the plan,

“(iv) procedures used by the plan to control utilization of services and expenditures,

“(v) procedures used by the plan to assure quality of care,

“(vi) the plan’s loss ratio, and

“(vii) rights and responsibilities of enrollees; and

“(B) in addition, for each managed care plan, on—

“(i) restrictions on payment for services provided outside the plan’s provider network,

“(ii) the process by which services may be obtained through the plan’s provider network,

“(iii) coverage for out-of-area services, and

“(iv) any exclusions in the types of providers participating in the plan’s provider network.

“(3) DISSEMINATION OF INFORMATION.—Carriers, agents, and brokers shall provide the information described in this subsection to individuals and employers seeking to purchase health coverage.

“(c) DISCLOSURE OF UTILIZATION REVIEW AND QUALITY STANDARDS.—Upon the request of any individual with respect to an insured health plan offered in the State, the State shall make available information on—

“(1) procedures used by the plan to control utilization of services and expenditures, and

“(2) procedures used by the plan to assure quality of care.

“SEC. 2222. REQUIREMENTS FOR ARRANGEMENTS WITH ESSENTIAL COMMUNITY PROVIDERS.

“(a) IN GENERAL.—Each carrier providing an insured health benefit plan shall, with respect to each essential community provider (as defined in subsection (c)) located within the plan’s service area, offer to enter into a written provider participation agreement (described in subsection (b)) with the provider.

“(b) PARTICIPATION AGREEMENT.—A participation agreement between a carrier and an essential community provider under this subsection shall provide that the plan agrees to treat the provider in accordance with terms and conditions at least as favorable as those that are applicable to other providers with a participation agreement with the plan with respect to the scope of services for which payment is made by the plan to the provider.

“(c) ESSENTIAL COMMUNITY PROVIDERS DESCRIBED.—In this section, an ‘essential community provider’ means any of the following:

“(1) CERTAIN MEDICARE DISPROPORTIONATE SHARE HOSPITALS.—A hospital—

“(A) described in section 1886(d)(5)(F)(i)(II);

“(B) described in section 1886(d)(5)(F)(iv)(I) with a disproportionate patient percentage (as defined in section 1886(d)(5)(F)(vi)) greater than 20.2;

or

“(C) that would be described in subparagraph (A) or (B) if—

“(i) the hospital were a subsection (d) hospital (as defined in section 1886(d)(1)(B)), or

“(ii) in the case of a hospital whose inpatients are predominantly individuals under 18 years of age, if the hospital were a subsection (d) hospital with more than 100 beds.

"(2) DESIGNATED CANCER HOSPITALS.—A hospital that the Secretary has classified as a hospital involved extensively in treatment for or research on cancer, as described in section 1886(d)(1)(B)(v).

"(3) SOLE COMMUNITY HOSPITALS.—A sole community hospital (as described in section 1886(d)(5)(D)(iii)).

"(4) MEDICARE-DEPENDENT, SMALL RURAL HOSPITALS.—A medicare-dependent, small rural hospital (as described in section 1886(d)(5)(G)(iii)), or a hospital that would be a medicare-dependent, small rural hospital if the hospital were a subsection (d) hospital (as defined in section 1886(d)(1)(B)).

"(5) FEDERALLY QUALIFIED HEALTH CENTERS.—A Federally qualified health center (as defined in section 1861(aa)(4)) or an entity that would be such a center but for its failure to meet the requirement described in section 329(f)(2)(G)(i) of the Public Health Service Act or the requirement described in section 330(e)(3)(G)(i) of such Act (relating to the composition of the entity's governing board).

"(6) RURAL HEALTH CLINICS.—A rural health clinic (as defined in section 1861(aa)(2)).

"(7) FAMILY PLANNING CLINICS.—A family planning project receiving a grant or contract under title X of the Public Health Service Act.

"(8) STATE DIAGNOSTIC AND TREATMENT CENTERS.—A nonprofit center or clinic that is licensed under a State law in effect as of January 1, 1994, as a diagnostic and treatment center which provides primary care services (including obstetric and gynecology services) in an area—

"(A) designated by the Secretary as a health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act, or

"(B) with a significant number of individuals who are members of a medically underserved population designated by the Secretary under section 330 of such Act.

"(9) LOCAL HEALTH DEPARTMENTS.—A health department of a unit of State or local government which provides health services directly to individuals.

"(10) PROVIDERS SERVING UNDERSERVED AREAS.—

"(A) IN GENERAL.—Any provider of health care services who meets the requirement of subparagraph (B) (if applicable) and—

"(i) who furnishes services not less than 20 hours per week—

"(I) in an area designated by the Secretary as a health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act, or

"(II) in an area with a significant number of individuals who are members of a medically underserved population designated by the Secretary under section 330 of such Act; or

"(ii) who—

"(I) serves in a neighborhood or community in which persons reside who are at risk of being medically underserved (in accordance with criteria established by the Secretary) for at least 20 hours per week at the principal site, and

"(II) is available to patients evenings and weekends at the principal site.

"(B) REQUIREMENT FOR PHYSICIANS.—In the case of an individual provider who is a physician, the provider must be board certified, hold hospital staff privileges, or be affiliated with one or more physicians holding hospital staff privileges.

"(d) SPECIAL RULE FOR PAYMENTS TO CERTAIN ESSENTIAL COMMUNITY PROVIDERS.—In the case of services in the guaranteed national benefit package that are furnished to an enrollee of an insured health benefit plan by any Federally qualified health center (described in subsection (c)(5)) or rural health clinic (described in subsection (c)(6)), the amount of payment made to the center or clinic for such services shall be determined in accordance with the payment methodology used to determine the amount of payment to such a center for services furnished under part B of title XVIII, unless the center or clinic elects to receive payment under an alternative methodology.

"SEC. 2223. REQUIREMENTS RELATING TO PLAN SOLVENCY.

"(a) IN GENERAL.—A carrier shall comply with the following procedures and requirements in order to assure solvency of insured health benefit plans provided by the carrier:

"(1) The carrier shall permit the applicable regulatory authority to examine financial records.

"(2) The carrier shall have and maintain a minimum level of capital and surplus to conduct business, and to obtain additional surplus capital if necessary.

"(3) The carrier shall use specified accounting practices and procedures.

"(4) The carrier shall comply with such corrective actions, and shall cease such practices which, if not corrected, would jeopardize the financial solvency of the carrier, as the applicable regulatory authority may require.

"(5) The carrier shall own securities only in accordance with recognized investment standards.

"(6) The carrier shall have a diversified investment portfolio.

"(b) AUTHORITY OF APPLICABLE REGULATORY AUTHORITIES IN RELATION TO FINANCIAL SOLVENCY.—Each applicable regulatory authority, with respect to carriers and insured health benefit plans over which it exercises authority—

"(1) may examine records of the carriers,

"(2) may specify the accounting practices and procedures to be used by the carriers,

"(3) may order the carriers to take corrective actions and to cease practices which, if not corrected, would jeopardize the financial solvency of the carrier,

"(4) may assume the administration of insolvent carriers, and

"(5) may take any actions necessary to assure the payment of claims on behalf of individuals enrolled in insured health benefit plans provided by insolvent carriers.

"(c) PROTECTION OF ENROLLEES.—In the case of an insured health benefit plan that becomes insolvent and fails to pay a provider for an item or service covered under the plan that is furnished to an individual enrolled under the plan, the individual enrollee shall not be liable for any amounts owed by the plan to the providers with respect to such item or service.

"SEC. 2224. UTILIZATION REVIEW.

"(a) REQUIRING REVIEW TO MEET STANDARDS.—A carrier offering an insured health plan may not deny coverage of or payment for items and services on the basis of a utilization review program unless the program meets the standards established by the Secretary under this section.

"(b) ESTABLISHMENT OF STANDARDS BY SECRETARY.—The Secretary shall establish standards for utilization review programs of insured health plans, consistent with subsection (b), and shall periodically review and update such standards to reflect changes in the delivery of health care services. The Secretary shall establish such standards in consultation with appropriate parties.

"(c) REQUIREMENTS FOR STANDARDS.—Under the standards established under subsection (a)—

"(1) individuals performing utilization review may not receive financial compensation based upon the number of denials of coverage;

"(2) negative determinations of the medical necessity or appropriateness of services or the site at which services are furnished may be made only by clinically qualified personnel;

"(3) the utilization review program shall provide for a process under which an enrollee or provider may obtain timely review of a denial of coverage;

"(4) utilization review shall be conducted in accordance with uniformly applied standards that are based on the most currently available medical evidence; and

"(5) providers shall participate in the development of the utilization review program.

"SEC. 2225. ADDITIONAL REQUIREMENTS FOR INSURED HEALTH BENEFIT PLANS.

"In addition to the requirements imposed by the preceding provisions of this part, each carrier providing an insured health benefit plan shall meet the following additional requirements:

"(1) ISSUANCE OF HEALTH SECURITY CARDS; COORDINATION OF INDIVIDUAL ENTITLEMENT.—The carrier shall issue health security cards and carry out other administrative functions in accordance with regulations developed by the Secretary including the issuance of an annual written statement to enrollees verifying enrollment in a private health plan and the provision of information on enrollees to the Secretary which the Secretary may forward to the Secretary of the Treasury.

"(2) COMPLIANCE WITH PAYMENT RULES.—The carrier provides for payment for items and services consistent with any State provider reimbursement system or State benefit management program approved under title IV of the Health Security Act.

“(3) OTHER REQUIREMENTS UNDER HEALTH SECURITY ACT.—The carrier shall meet the applicable requirements of the following provisions of the Health Security Act:

“(A) Subtitle A of title IX (relating to grievance and appeals procedures, participation in the National Quality Management Program, and the privacy of information on enrollees).

“(B) Subtitle B of title IX (relating to data management and reporting and administrative simplification).”.

Subtitle B—Standards for Sponsors and Self-Insured Health Benefit Plans

SEC. 5101. ESTABLISHMENT OF FEDERAL STANDARDS.

(a) ESTABLISHMENT.—Section 2201(a) of the Social Security Act, as added by section 5001(a), is amended to read as follows:

“(a) ESTABLISHMENT OF GENERAL STANDARDS FOR HEALTH BENEFIT PLANS.—

“(1) STANDARDS FOR CARRIERS PROVIDING INSURED HEALTH BENEFIT PLANS.—Not later than July 1, 1995, the Secretary shall establish standards for carriers providing insured health benefit plans consistent with this section and the requirements described in part B.

“(2) STANDARDS FOR SPONSORS OF SELF-INSURED HEALTH BENEFIT PLANS.—Not later than July 1, 1995, the Secretary shall establish and publish standards for self-insured health benefit plans and the sponsors of such plans consistent with this section and the requirements of part C. Under such standards, the Secretary would annually certify (for years beginning with 1996) each self-insured health benefit plan found by the Secretary to be in compliance with such standards, based on information provided by the plans in such manner and format as the Secretary considers appropriate.”.

(b) REQUIRING PLANS TO BE CERTIFIED.—

(1) IN GENERAL.—Section 2202 of such Act, as added by section 5001(a), is amended—

(A) in subsection (a)(1)(A), by striking “subsection (b)” and inserting “subsection (c)”;

(B) in subsection (a)(2), by striking “subsection (c)” and inserting “subsection (d)”;

(C) by redesignating subsections (b) and (c) as subsections (c) and (d); and

(D) by inserting after subsection (a) the following new subsection:

“(b) CERTIFICATION OF SPONSORS OFFERING SELF-INSURED HEALTH BENEFIT PLANS.—

“(1) IN GENERAL.—No sponsor may offer a self-insured health benefit plan (as defined in section 2204(11)) during a year on or after the effective date specified in subsection (d) (and may not enroll any individual under such a plan beginning on or after such effective date) unless the plan has been certified for the year by the Secretary (in accordance with such procedures as the Secretary establishes) as meeting the applicable standards established under section 2201(a)(2).”.

(2) EFFECTIVE DATE.—Section 2202(d)(1) of such Act, as added by section 5001(a) and redesignated by paragraph (1)(C), is amended by striking “shall apply” and all that follows and inserting the following: “shall apply—

“(A) to contracts under insured health benefit plans sold, issued, or renewed on or after January 1, 1997; or

“(B) to contracts under a self-insured health benefit plan sold, issued, or renewed on or after January 1, 1996.”.

(c) ENFORCEMENT.—Section 2203(a)(1)(B) of such Act, as added by section 5001(c), is amended—

(1) in clause (i), by striking “Section 2212” and inserting “Sections 2212 and 2232”;

(2) in clause (ii), by striking “Section 2213” and inserting “Sections 2213 and 2233”;

(3) in clause (iii), by striking “Section 2214” and inserting “Sections 2214 and 2234”; and

(4) in clause (vi), by striking “Section 2222” and inserting “Sections 2222 and 2239”.

(d) DESCRIPTION OF STANDARDS.—Title XXII of the Social Security Act, as added by section 5001(a), is amended by adding at the end the following new part:

"PART C—STANDARDS FOR SELF-INSURED HEALTH BENEFIT PLANS DESCRIBED

"SEC. 2231. LIMITATION ON ELIGIBLE SPONSORS.

"(a) IN GENERAL.—No entity may serve as the sponsor of a self-insured health benefit plan unless the entity is an eligible sponsor (as defined in subsection (b)) who elects, in a form and manner specified by the Secretary consistent with this subtitle, to be treated as the sponsor of such a plan and to be subject to the standards established by the Secretary for such plans under section 2201(a)(2).

"(b) ELIGIBLE SPONSORS.—

"(1) IN GENERAL.—In this section, each of the following is an eligible sponsor:

"(A) LARGE EMPLOYER.—An employer that is a large employer as of the date of an election under subsection (a), with respect to employees, former employees, and family members.

"(B) PLAN SPONSOR OF A MULTIEMPLOYER PLAN.—A plan sponsor described in section 3(16)(B)(iii) of Employee Retirement Income Security Act of 1974, but only with respect to participants and beneficiaries (as defined in section 3 of such Act) covered under a group health plan that is a multi-employer plan (as defined in subsection (c)(3)) maintained by the sponsor and only if (as of the date of an election under subsection (a)) such plan—

"(i) covers more than 100 full-time employees in the United States, or

"(ii) the plan is maintained by one or more affiliates of the same labor organization, or one or more affiliates of labor organizations representing employees in the same industry, covering more than 100 full-time employees.

"(C) RURAL ELECTRIC COOPERATIVE AND RURAL TELEPHONE COOPERATIVE ASSOCIATION.—A rural electric cooperative or a rural telephone cooperative association, but only with respect to employees, former employees, and family members covered under a group health plan that is maintained by such cooperative or association (or members of such cooperative or association) and only if such plan has more than 100 employees in the United States entitled to benefits under the plan.

"(2) EXCLUSION OF SPONSORS OF MEWAS.—The plan sponsor of a multiple employer welfare arrangement may not be considered an eligible sponsor under this subsection.

"(c) DEFINITIONS.—In this section, except as otherwise provided:

"(1) GROUP HEALTH PLAN.—The term 'group health plan' means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974) providing medical care (as defined in section 213(d) of the Internal Revenue Code of 1986) to participants or beneficiaries (as defined in section 3 of the Employee Retirement Income Security Act of 1974) directly or through insurance, reimbursement, or otherwise.

"(2) LARGE EMPLOYER.—The term 'large employer' has the meaning given such term in section 3451(d) of the Internal Revenue Code of 1986.

"(3) MULTIEMPLOYER PLAN.—The term 'multiemployer plan' has the meaning given such term in section 3(37) of the Employee Retirement Income Security Act of 1974, and includes any plan that is treated as such a plan under title I of such Act.

"(4) MULTIPLE EMPLOYER WELFARE ARRANGEMENT.—The term 'multiple employer welfare arrangement' has the meaning given such term in section 3(40) of the Employee Retirement Income Security Act of 1974.

"(5) RURAL ELECTRIC COOPERATIVE.—The term 'rural electric cooperative' has the meaning given such term in section 3(40)(A)(iv) of the Employee Retirement Income Security Act of 1974.

"(6) RURAL TELEPHONE COOPERATIVE ASSOCIATIONS.—The term 'rural telephone cooperative association' has the meaning given such term in section 3(40)(A)(v) of the Employee Retirement Income Security Act of 1974.

"SEC. 2232. NON-DISCRIMINATION.

"(a) NO DISCRIMINATION BASED ON HEALTH STATUS.—The sponsor of a self-insured health benefit plan may not deny, limit, or condition the coverage under (or benefits of) the plan, or vary the premium charged under the plan, based on the health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability, of an individual.

"(b) OTHER DISCRIMINATION PROHIBITED.—Section 2212(b) shall apply with respect to a sponsor of a self-insured health benefit plan in the same manner as such provisions apply with respect to a carrier providing an insured health benefit plan.

"SEC. 2233. REQUIREMENTS FOR OPEN ENROLLMENT.

"(a) **ANNUAL OPEN ENROLLMENT PERIOD.**—The sponsor of a self-insured health benefit plan shall have an annual open enrollment period of at least 45 days during which individuals eligible to enroll in the plan may change the health benefit plan under which they are provided coverage.

"(b) **CHANGES IN ENROLLMENT DURING 1ST YEAR OF ENROLLMENT.**—Once during the first year for which an individual is enrolled in a plan offered by the sponsor of a self-insured health benefit plan, the individual may change the health benefit plan in which the individual is enrolled. Such a change shall be effective on the first day of the first month beginning at least 45 days after the date the sponsor receives a notice of change of coverage.

"(c) **ENROLLMENT OF NEWLY ELIGIBLE INDIVIDUALS.**—The sponsor of a self-insured health benefit plan may not refuse to enroll an individual who is eligible to enroll in a health benefit plan offered by the sponsor and is not enrolled in such a plan.

"SEC. 2234. PROHIBITION ON PRE-EXISTING CONDITION EXCLUSIONS.

"The provisions of section 2214(a) shall apply with respect to the sponsor of a self-insured health benefit plan in the same manner as such provisions apply with respect to a carrier providing an insured health benefit plan.

"SEC. 2235. PROHIBITION ON WAITING PERIODS.

"(a) **IN GENERAL.**—The provisions of section 2215(a) shall apply with respect to the sponsor of a self-insured health benefit plan in the same manner as such provisions apply with respect to a carrier providing an insured health benefit plan.

"(b) **COVERAGE AFTER ENROLLMENT DURING ANNUAL OPEN ENROLLMENT PERIOD.**—In the case of an individual who enrolls in a self-insured health benefit plan during an open enrollment period described in section 2233(b), the sponsor shall provide coverage of the individual under the plan effective as of such date as the sponsor may establish with respect to enrollments made during such period (consistent with the standards established by the Secretary under section 2201(c)).

"SEC. 2236. BENEFIT REQUIREMENTS.

"(a) **OFFER OF PLAN CONSISTING OF GUARANTEED NATIONAL BENEFIT PACKAGE.**—Each sponsor of a self-insured health benefit plan—

"(1) shall offer all enrollees a health benefit plan consisting only of coverage for the benefits (including cost-sharing) contained in the guaranteed national benefit package established under title XXI; and

"(2) may offer a health benefit plan consisting of coverage for the benefits described in paragraph (1) and (subject to subsection (d)) additional benefits.

"(b) **OFFER OF PLAN PROVIDING UNLIMITED CHOICE OF PROVIDERS.**—Each sponsor of a self-insured health benefit plan shall assure that all enrollees are offered coverage in—

"(1) at least one managed care plan (unless there is no such plan available in the area); and

"(2) at least one unlimited-choice-of-provider plan, which may be a point-of-service plan.

"(c) **SPECIAL RULE FOR ENROLLEES COVERED UNDER STATE MANAGED MENTAL HEALTH PROGRAMS.**—The provisions of section 2217(c) shall apply to sponsors of self-insured health benefit plans in the same manner as they apply to carriers providing insured health benefit plans.

"(d) **NON-DISCRIMINATION IN ADDITIONAL BENEFITS FOR NON-EMPLOYER PLANS.**—In the case of a self-insured health benefit plan with an eligible sponsor described in subparagraph (B) or (C) or section 2231(b)(1), if the sponsor offers additional benefits pursuant to subsection (a)(2) that consist of a reduction in the cost-sharing imposed under a plan, the sponsor shall provide such additional benefits to all enrollees in the same manner as an employer would be required under section 4980C(f) of the Internal Revenue Code of 1986 to provide for equal benefits with respect to all full-time employees.

"SEC. 2237. REQUIREMENTS RELATING TO RATING OF PREMIUMS.

"(a) **CHARGING RATES BY CLASS OF ENROLLMENT.**—The sponsor of a self-insured health benefit plan shall establish separate premium rates for each of the three classes of enrollment described in section 3(b) of the Health Security Act.

"(b) **VARIATIONS ONLY BY ACTUARIAL VALUE.**—

"(1) **IN GENERAL.**—The differences among premium rates established under subsection (a) shall reflect only differences in the actuarial value of the guaranteed national benefit package among the classes of enrollment, consistent with standards established by the Secretary.

"(2) PERMITTING VARIATION BY GEOGRAPHIC AREA OF ENROLLMENT.—At the option of the sponsor of a self-insured health benefit plan, in applying paragraph (1) the sponsor may vary premium rates based on differences in the actuarial value of the package among classes of enrollment in geographic areas, but only if the geographic areas applied are the same as the communities established by a State under section 2218(d) with respect to insured health benefit plans offered in the State.

"(c) EXCEPTION FOR SPONSORS PAYING ENTIRE PREMIUM.—Subsections (a) and (b) shall not apply in the case of a self-insured health benefit plan offered by a sponsor for which the sponsor does not require the enrollee to contribute any portion of the applicable premium.

"SEC. 2238. ADDITIONAL STANDARDS FOR MANAGED CARE PLANS AND POINT-OF-SERVICE PLANS.

"The provisions of section 2219 shall apply with respect to a managed care plan and a point-of-service plan provided by the sponsor of a self-insured health benefit plan in the same manner as such provisions apply with respect to a managed care plan and point-of-service plan provided by the carrier providing an insured health benefit plan.

"SEC. 2239. PROVISION OF PLAN INFORMATION.

"(a) IN GENERAL.—The sponsor of a self-insured health benefit plan shall annually prepare and make available to individuals eligible to enroll in the plan, in a uniform format, information on the plans offered by the sponsor.

"(b) INFORMATION DESCRIBED.—The information required to be provided under subsection (a) shall include summary information described in section 2221(b)(2) (other than information described in subparagraph (A)(vi)).

"(c) DISCLOSURE OF UTILIZATION REVIEW AND QUALITY STANDARDS.—Upon the request of any individual eligible to enroll in a self-insured health benefit plan offered by a sponsor, the sponsor shall make available information on—

"(1) procedures used by the plan to control utilization of services and expenditures, and

"(2) procedures used by the plan to assure quality of care.

"SEC. 2240. REQUIREMENTS FOR ARRANGEMENTS WITH ESSENTIAL COMMUNITY PROVIDERS.

"The provisions of section 2222 shall apply with respect to the sponsor of a self-insured health benefit plan in the same manner as such provisions apply with respect to a carrier providing an insured health benefit plan.

"SEC. 2241. REQUIREMENTS RELATING TO PLAN SOLVENCY.

"(a) IN GENERAL.—The sponsor of a self-insured health benefit plan shall demonstrate to the satisfaction of the Secretary that the plan meets solvency standards established by the Secretary for such plans, which may include requirements regarding the purchase of stop-loss coverage by the sponsor.

"(b) PROTECTION OF ENROLLEES.—In the case of self-insured health benefit plan that becomes insolvent and fails to pay a provider for an item or service covered under the plan that is furnished to an individual enrolled under the plan, the individual enrollee shall not be liable for any amounts owed by the plan to the providers with respect to such item or service.

"SEC. 2242. UTILIZATION REVIEW.

"The provisions of section 2224 shall apply with respect to a utilization review program of a self-insured health benefit plan in the same manner as such provisions apply with respect to a utilization review program of an insured health benefit plan.

"SEC. 2243. ADDITIONAL REQUIREMENTS FOR SELF-INSURED HEALTH BENEFIT PLANS.

"The additional requirements described in section 2225 shall apply with respect to the sponsor of a self-insured health benefit plan in the same manner as such additional requirements apply with respect to a carrier providing an insured health benefit plan, except that the requirements of paragraph (2) of such section shall not apply in the case of a sponsor who is not required to participate in a State benefit management program under title IV of the Health Security Act."

Subtitle C—Standards for Supplemental Health Plans

SEC. 5201. STANDARDS FOR PLANS THAT SUPPLEMENT THE GUARANTEED NATIONAL BENEFIT PACKAGE.

(a) ESTABLISHMENT OF STANDARDS.—

(1) IN GENERAL.—Section 2201(a) of the Social Security Act, as added by section 5001(a) and as amended by section 5101(a), is amended by adding at the end the following new paragraph:

“(3) STANDARDS FOR PLANS THAT SUPPLEMENT THE GUARANTEED NATIONAL BENEFIT PACKAGE.—Not later than July 1, 1995, the Secretary shall establish standards for supplemental health benefit policies in accordance with the requirements for such policies (and the entities offering such policies) consistent with this section and the requirements described in part D.”.

(2) SUPPLEMENTAL HEALTH BENEFIT POLICY DEFINED.—Section 2204 of the Social Security Act, as added by section 5001(a), is amended—

(A) by redesignating paragraph (14) as paragraph (15); and

(B) by inserting after paragraph (13) the following new paragraph:

“(14) SUPPLEMENTAL HEALTH BENEFIT POLICY.—

“(A) IN GENERAL.—The term ‘supplemental health benefit policy’ means a health insurance policy or health benefit plan which provides—

“(i) coverage for items and services not included in the guaranteed national benefit package established under title XXI, or

“(ii) coverage for items and services included in such package but not covered because of a limitation in amount, duration, or scope of benefits (including coverage for cost-sharing),

or both.

“(B) EXCLUSIONS.—Such term does not include the following:

“(i) Coverage only for accident, disability income, or long-term care insurance, or any combination thereof.

“(ii) Medicare supplemental health insurance.

“(iii) Coverage issued as a supplement to liability insurance.

“(iv) Liability insurance, including general liability insurance and automobile liability insurance.

“(v) Worker’s compensation or similar insurance.

“(vi) Automobile medical-payment insurance.

“(vii) Coverage for a specified disease or illness.

“(viii) A hospital or fixed indemnity policy.

“(ix) Coverage provided exclusively to individuals who are not eligible individuals under the Health Security Act.

“(C) EXCEPTION FOR SERVICES COVERED UNDER CERTIFIED SELF-INSURED PLAN.—Such term does not include any self-insured health benefit plan certified by the Secretary under section 2201(a)(1)(B) as meeting the standards established by the Secretary under section 5102(a) of the Health Security Act (in accordance with the requirements of part C), notwithstanding that the plan provides coverage for any item or service described in subparagraph (A).”

(b) REQUIREMENT FOR CERTIFICATION.—

(1) IN GENERAL.—Section 2202 of the Social Security Act, as added by section 5003 and as amended by section 5102(b), is amended—

(A) in subsection (a)(1), by inserting after “in a State” the following: “, or sell, issue, or renew a contract under a supplemental health benefit policy (as defined in section 2204(11)) with respect to any individual or group in a State,”; and

(B) in subsection (a)(2), by inserting “or a supplemental health benefit policy” after “insured health benefit plan”.

(2) USE OF APPROVED STATE REGULATORY PROGRAMS.—Section 2202(c) of such Act, as added by section 5003 and as redesignated by section 5102(b)(1)(C), is amended—

(A) in paragraphs (2) and (3), by inserting “or supplemental health benefit policies (as the case may be)” after “insured health benefit plans” each place it appears; and

(B) in paragraph (1), by striking “program for the application” and all that follows and inserting the following: “program—

“(A) for the application of the standards established under part B to carriers providing insured health benefit plans and providing for collecting and

disseminating information with respect to such plans under section 2219, the Secretary may approve such program for purposes of certification of carriers and insured health benefit plans under this title; and

“(B) for the application of the standards established under part D to carriers providing supplemental health benefit policies and providing for collecting and disseminating information with respect to such policies under section 2235(b), the Secretary may approve such program for purposes of certification of carriers and supplemental health benefit policies under this title.”.

(c) ENFORCEMENT.—

(1) IN GENERAL.—Section 2203(a)(1)(B) of such Act, as added by section 5001(c) and as amended by section 5101(c), is amended—

(1) in clause (i), by striking “Sections 2212 and 2232” and inserting “Sections 2212, 2232, 2253”;

(2) in clause (ii), by striking “Sections 2213, 2233, and 2254”;

(3) in clause (iii), by striking “Sections 2214, 2234, and 2255”; and

(4) in clause (v), by striking “Section 2220” and inserting “Sections 2220 and 2258”.

(2) PENALTY FOR CERTAIN POLICIES.—Section 2203 of such Act is further amended by adding at the end the following new subsection:

“(c) PENALTY FOR CERTAIN POLICIES DUPLICATING COVERAGE.—

“(1) IN GENERAL.—Any person who sells or issues a health plan described in paragraph (4) that duplicates coverage of any item or service covered under the guaranteed national benefit package is subject to a civil money penalty not to exceed \$10,000 for each such violation. Paragraph (2) of subsection (a) shall apply with respect to a penalty under the previous sentence in the same manner as such paragraph applies to penalties under such subsection.

“(2) EXCEPTION FOR PLANS PROVIDING BENEFITS WITHOUT REGARD TO OTHER COVERAGE.—Paragraph (1) shall not apply with respect to any health plan that provides benefits to an enrollee without regard to any benefits provided to the enrollee under another plan.

“(3) EXCEPTION FOR LIABILITY INSURANCE COVERAGE.—Paragraph (1) shall not apply with respect to any health plan described in clause (iv) or (v) of section 2204(14)(B) that provides benefits to an enrollee without regard to any benefits provided to the enrollee under a plan other than a plan described in such clause.

“(4) PLANS DESCRIBED.—The health plans referred to in this paragraph are the plans described in section 2204(14)(B).”.

(d) STANDARDS DESCRIBED.—Title XXII of the Social Security Act, as added by section 5001(a) and as amended by section 5101(c), is amended by adding at the end the following new part:

“PART D—REQUIREMENTS FOR SUPPLEMENTAL HEALTH BENEFIT POLICIES DESCRIBED

“SEC. 2251. STANDARDIZED BENEFITS.

“(a) LIMITATION ON POLICIES PERMITTED.—An entity may not offer a supplemental health benefit policy unless the benefits covered by the policy meet the requirements for one of the standard benefit packages established by the Secretary under subsection (b).

“(b) ESTABLISHMENT OF STANDARDIZED PACKAGES.—

“(1) IN GENERAL.—Not later than July 1, 1995, the Secretary shall establish not more than 10 standardized benefit packages for supplemental health benefit policies under this part. At least one of the packages shall be designed to supplement a managed care plan.

“(2) CRITERIA USED IN ESTABLISHING PACKAGES.—In establishing standardized benefit packages under paragraph (1), the Secretary shall take into account State laws that mandate the inclusion of particular benefits and providers of services, and the benefits typically offered by health plans that are not included in the guaranteed national benefit package.

“SEC. 2252. PROHIBITING OFFER OF MULTIPLE PACKAGES TO INDIVIDUAL.

“An entity may not offer a supplemental health benefit policy to an individual who is covered under another such policy, unless the individual’s coverage under the new policy begins only after the individual’s coverage under the original policy is terminated.

"SEC. 2253. NON-DISCRIMINATION REQUIREMENTS.

"The provisions of section 2211(b) shall apply with respect to an entity offering a supplemental health benefit policy in the same manner as such provisions apply with respect to a carrier providing an insured health benefit plan.

"SEC. 2254. OPEN ENROLLMENT.

"The State shall establish an annual open enrollment period of at least 30 days during which an entity offering a supplemental health benefit policy may not refuse to enroll an individual who seeks coverage under the policy.

"SEC. 2255. PROHIBITION ON PRE-EXISTING CONDITION EXCLUSIONS.

"(a) DURING ANNUAL OPEN ENROLLMENT PERIOD.—An entity offering a supplemental health benefit policy may not exclude or limit coverage under the policy during the annual open enrollment period established under section 2234 with respect to services covered under the policy related to treatment of a pre-existing condition.

"(b) DURING OTHER PERIODS.—

"(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, an entity offering a supplemental health benefit policy may exclude coverage during any period other than the annual open enrollment period established under section 2234 with respect to services related to treatment of a pre-existing condition, but the period of such exclusion may not exceed 6 months and shall not apply to services furnished to newborns.

"(2) CREDITING OF PREVIOUS COVERAGE.—

"(A) IN GENERAL.—An entity offering a supplemental health benefit policy shall provide that if an individual covered under such a policy is in a period of continuous coverage (as defined in subparagraph (B)(i)) with respect to particular services as of the date of initial coverage under such policy, any period of exclusion of coverage with respect to a preexisting condition for such services or type of services shall be reduced by 1 month for each month in the period of continuous coverage.

"(B) DEFINITIONS.—As used in this paragraph:

"(i) PERIOD OF CONTINUOUS COVERAGE.—The term 'period of continuous coverage' means, with respect to particular services, the period beginning on the date an individual is enrolled under any plan or policy which provides benefits with respect to the same or substantially similar services (as determined in accordance with criteria established by the Secretary) and ends on the date the individual is not so enrolled for a continuous period of more than 3 months.

"(ii) PREEXISTING CONDITION.—The term 'preexisting condition' means a condition which has been diagnosed or treated during the 6-month period ending on the day before the first date of the individual's coverage (without regard to any waiting period).

"SEC. 2256. CONTINUATION OF COVERAGE REQUIREMENT.

"The provisions of section 2216 (other than subsection (b) of such section) shall apply with respect to an entity offering a supplemental health benefit policy in the same manner as such provisions apply with respect to a carrier offering an insured health benefit plan.

"SEC. 2257. COMMUNITY RATING REQUIREMENTS.

"(a) IN GENERAL.—The premium rate charged by an entity for a supplemental health benefit policy consisting of a standard benefit package established by the Secretary under section 2231 in a community for a class of enrollment shall be the same for all such enrollments.

"(b) REFERENCES TO COMMUNITY AND ENROLLMENT.—The 'community' and 'class of enrollment' applicable under subsection (a) are the community and class of enrollment applicable to the community rating of premiums for insured health benefit plans required section 2218.

"SEC. 2258. MARKETING REQUIREMENTS.

"(a) RESTRICTIONS ON TIE-INS WITH HEALTH BENEFIT PLANS.—

"(1) IN GENERAL.—An entity offering a supplemental health benefit policy may not condition the offer of a health benefit plan to an individual on the purchase of the supplemental health benefit policy by the individual.

"(2) RESTRICTION ON AUTHORITY OF MANAGED CARE PLANS TO OFFER SUPPLEMENTAL POLICIES.—A carrier providing a managed care plan which provides for coverage of the guaranteed national benefit package may not offer a supplemental health benefit policy to any individual unless the individual is enrolled in such managed care plan.

“(b) APPROVAL OF MATERIALS.—The provisions of section 2220 shall apply with respect to an entity offering a supplemental health benefit policy in the same manner as such provisions apply with respect to a carrier providing an insured health benefit plan.”.

SEC. 5202. MEDICARE SUPPLEMENTAL INSURANCE POLICY AMENDMENTS.

(a) CONFORMING CHANGES IN MEDICARE BENEFITS.—Not later than July 1, 1995, the Secretary shall, in accordance with section 1882(p)(1) of the Social Security Act, promulgate standards for medicare supplemental policies to reflect the changes in benefits provided under parts A and B of title XVIII of such Act for purposes of the NAIC or Federal Standards applicable under such section. The provisions of section 1882(p)(1) of the Social Security Act shall apply to such standards in the same manner as such provisions apply to “Federal standards” described in subparagraph (B) of such section, except that any reference in such section to “the date specified in subparagraph” shall be deemed to be a reference to “January 1, 1998”.

(b) REQUIRING OPEN ENROLLMENT.—

(1) IN GENERAL.—Section 1882(s) of the Social Security Act (42 U.S.C. 1395ss(s)) is amended—

(A) in paragraph (3), by striking “paragraphs (1) and (2)” and inserting “paragraphs (1), (2), and (3)”;

(B) by redesignating paragraph (3) as paragraph (4); and

(C) by inserting after paragraph (2) the following new paragraph:

“(3) Notwithstanding paragraph (2), the issuer of a medicare supplemental policy may not deny the issuance of a medicare supplemental policy during an annual open enrollment period of at least 30 days established by the Secretary for medicare supplemental policies.”.

(2) ISSUANCE OF REGULATIONS.—Not later than July 1, 1995, the Secretary shall issue regulations to carry out the amendments made by paragraph (1).

(c) EFFECTIVE DATE.—

(1) CONFORMING CHANGES.—The changes in the NAIC or Federal standards made pursuant to subsection (a) shall apply to medicare supplemental policies issued on or after January 1, 1998.

(2) OPEN ENROLLMENT.—(A) Except as provided in subparagraph (B), the amendments made by subsection (b) shall apply to medicare supplemental policies issued on or after January 1, 1997.

(B) In the case of a State which the Secretary identifies as—

(i) requiring State legislation (other than legislation appropriating funds) to conform its regulatory program to the amendments made by subsection (b), but

(ii) having a legislature which is not scheduled to meet in 1996 in a legislative session in which such legislation may be considered, the amendment made by subsection (b) shall apply to medicare supplemental policies issued in the State on or after the earlier of January 1, 1998, or the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1996. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

Subtitle D—Transitional Insurance Reforms

SEC. 5301. TRANSITIONAL INSURANCE REFORMS.

(a) ESTABLISHMENT OF TRANSITIONAL INSURANCE STANDARDS.—

(1) IN GENERAL.—The Secretary shall establish standards to carry out the requirements of this subtitle.

(2) CERTIFICATION OF COMPLIANCE.—For each 6-month period in which this subtitle is effective, each health plan sponsor shall file a certification with the Secretary (or with a State with which the Secretary has entered into an arrangement under paragraph (3)(C)) that the sponsor is in compliance with the requirements of this subtitle.

(3) ENFORCEMENT.—

(A) ISSUANCE OF REGULATIONS.—The Secretary shall issue regulations to carry out this subtitle, and is authorized to issue such regulations on an interim basis that become final on the date of publication, subject to change based on subsequent public comment. The Secretary may consult with States and the National Association of Insurance Commissioners in issuing regulations and guidelines under this subtitle.

(B) ARRANGEMENTS WITH STATES.—The Secretary may enter into arrangements with a State to enforce the requirements of this subtitle with respect to insured health benefit plans issued or sold, or established and maintained, in the State.

(4) SANCTIONS AND REMEDIES.—

(A) IN GENERAL.—Any health plan sponsor that violates a requirement of this subtitle shall be subject to a civil money penalty of not more than \$25,000 for each such violation. The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply to civil money penalties under this subparagraph in the same manner as they apply to a penalty or proceeding under section 1128A(a) of such Act.

(B) EQUITABLE REMEDIES.—A civil action may be brought by the Secretary—

(i) to enjoin any act or practice which violates any provision of this subtitle, or

(ii) to obtain other appropriate equitable relief (I) to redress such violations, or (II) to enforce any provision of this subtitle, including, in the case of a wrongful termination of (or refusal to renew) coverage, reinstating coverage effective as of the date of the violation.

(5) CONSTRUCTION.—The provisions of this subtitle shall be construed in a manner that assures, to the greatest extent practicable, continuity of health benefits under health benefit plans in effect on the effective date of this Act.

(6) SPECIAL RULES FOR ACQUISITIONS AND TRANSFERS.—The Secretary may issue regulations regarding the application of this subtitle in the case of insured health benefit plans (or groups of such plans) which are transferred from one carrier to another carrier through assumption, acquisition, or otherwise and in the case of plans terminated pursuant to a joint marketing agreement entered into prior to January 1, 1994.

(b) CONTINUATION OF COVERAGE.—

(1) PROHIBITION OF TERMINATION.—

(A) GROUP HEALTH INSURANCE PLANS.—Each health plan sponsor that provides a group health insurance plan for a group of employees may not terminate (or fail to renew) coverage for the group, or for any covered individual, if the employer of the employees continues the plan, except in the case of—

(i) nonpayment of required premiums, or

(ii) fraud or misrepresentation of a material fact relating to an application for coverage or claim for benefits.

(B) INDIVIDUAL HEALTH INSURANCE PLANS.—Each carrier providing an individual health insurance plan may not terminate (or fail to renew) coverage for an individual covered under the plan (or a covered dependent), except in the case of—

(i) nonpayment of required premiums,

(ii) fraud, or

(iii) misrepresentation of a material fact relating to an application for coverage or claim for benefits.

(C) SELF-INSURED HEALTH BENEFIT PLANS.—Each sponsor of a self-insured health benefit plan may not terminate (or fail to renew) coverage for an individual covered under the plan (or a covered dependent), except in the case of—

(i) nonpayment of required premiums,

(ii) fraud, or

(iii) misrepresentation of a material fact relating to an application for coverage or claim for benefits.

(2) ACCEPTANCE OF NEW MEMBERS IN A GROUP HEALTH INSURANCE PLAN.—

(A) IN GENERAL.—In the case of a health plan sponsor that provides a group health insurance plan that is in effect on the effective date of this subtitle, the sponsor is required—

(i) to accept all individuals, and their eligible dependents, who become full-time employees (as defined in section 3467(b)(1) of the Internal Revenue Code of 1986) of an employer covered after such effective date;

(ii) to establish and apply premium rates that are consistent with subsection (e); and

(iii) to limit the application of pre-existing condition restrictions in accordance with subsection (c).

(B) CONSISTENT APPLICATION OF RULES RELATING TO DEPENDENTS AND WAITING PERIODS.—In this paragraph, the term “eligible dependent”, with

respect to a group health insurance plan, has the meaning provided under the plan as of June 29, 1994, or, in the case of a plan not established as of such date, as of the date of establishment of the plan.

(c) LIMITS ON PRE-EXISTING CONDITION EXCLUSIONS.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, a carrier providing an insured health benefit plan may exclude coverage with respect to services related to treatment of a pre-existing condition, but the period of such exclusion may not exceed 6 months and such exclusion shall not apply with respect to services furnished to newborns or to a plan for which such exclusion did not apply as of the effective date of this subtitle.

(2) CREDITING OF PREVIOUS COVERAGE.—

(A) IN GENERAL.—A carrier providing an insured health benefit plan shall provide that if an individual covered under such a plan is in a period of continuous coverage (as defined in subparagraph (B)(i)) with respect to particular services as of the date of initial coverage under such plan, any period of exclusion of coverage with respect to a preexisting condition for such services or type of services shall be reduced by 1 month for each month in the period of continuous coverage.

(B) DEFINITIONS.—As used in this paragraph:

(i) PERIOD OF CONTINUOUS COVERAGE.—The term “period of continuous coverage” means, with respect to particular services, the period beginning on the date an individual is enrolled under a health benefit plan, the medicare program, a State medicaid plan, or other health benefit arrangement which provides benefits with respect to the same or substantially similar services (as determined in accordance with criteria established by the Secretary) and ends on the date the individual is not so enrolled for a continuous period of more than 3 months.

(ii) PREEXISTING CONDITION.—The term “preexisting condition” means, with respect to coverage under a health benefit plan, a condition which has been diagnosed or treated during the 6-month period ending on the day before the first date of such coverage (without regard to any waiting period).

(d) PREMIUM CHANGES TO REFLECT CHANGES IN GROUP OR INDIVIDUAL CHARACTERISTICS OR TERMS OF COVERAGE.—

(1) APPLICATION.—The provisions of this subsection shall apply to changes in premiums under insured health benefit plans that reflect—

(A) changes in the number of individuals covered under such a plan;

(B) changes in the group or individual characteristics (including age, gender, family composition or geographic area but not including health status, claims experience or duration of coverage under the plan) of individuals covered under such a plan;

(C) changes in the level of benefits (including changes in cost-sharing) under the plan; and

(D) changes in any material terms and conditions of the health benefit plan (other than factors related to health status, claims experience, and duration of coverage under the plan).

(2) DIVISION OF HEALTH INSURANCE PLANS BY SECTOR.—For purposes of this subsection, each health plan sponsor shall divide its health insurance business into the following 3 sectors:

(A) Health insurance for groups with at least 100 covered lives (in this subsection referred to as the “large group sector”)

(B) Health insurance for groups with fewer than 100 covered lives (in this subsection referred to as the “small group sector”).

(C) Health insurance for individuals, and not for groups (in this subsection referred to as the “individual sector”).

(3) SINGLE SET OF RATE FACTORS.—

(A) IN GENERAL.—Each health plan sponsor shall develop a single set of rate factors which will be used to calculate any changes in premium within a sector described in paragraph (2) that relate to the reasons described in subparagraphs (A) through (D) of paragraph (1).

(B) STANDARDS.—Such rate factors—

(i) shall relate to reasonable and objective differences in demographic characteristics, in the design and in levels of coverage, and in other terms and conditions of a contract,

(ii) shall not relate to expected health status, claims experience, or duration of coverage of the one or more groups or individuals, and

(iii) shall comply with regulations established under subsection (f).

(4) COMPUTATION OF PREMIUM CHANGES.—

(A) IN GENERAL.—Changes in premium rates within a sector that relate to the reasons described in paragraph (1) shall be calculated using the rate factors developed pursuant to paragraph (3).

(B) APPLICATION OF FACTORS.—

(i) IN GENERAL.—The change in premium rates with respect to each health benefit plan shall reflect the rate factors specified under paragraph (3) applicable to the reason as applied to the current premium charged for the plan. Such rate factors shall be applied in a manner so that the resulting adjustment, to the extent possible, reflects the premium that would have been charged under the plan if the reason for the change in premium had existed at the time that the current premium rate was calculated.

(ii) NO REFLECTION OF CHANGE IN HEALTH STATUS.—In applying the rate factors under this subparagraph, the adjustment shall not reflect any change in the health status, claims experience or duration of coverage with respect to any employer or individual covered under the plan.

(5) LIMITATION ON APPLICATION.—This subsection shall only apply—

(A) to changes in premiums occurring on or after the date of the enactment of this Act to groups and individuals covered as of such date, and

(B) with respect to groups and individuals subsequently covered, to changes in premiums subsequent to such coverage.

(6) APPLICATION TO COMMUNITY-RATED PLANS.—Nothing in this subsection shall require the application of rate factors related to individual or group characteristics with respect to any health benefit plan that, as of the date of the enactment of this Act, does not use such factors in the determination of premiums under the plan.

(e) LIMITATIONS ON CHANGES IN PREMIUMS FOR PLANS IN INDIVIDUAL SECTOR AND SMALL GROUP SECTOR RELATED TO INCREASES IN HEALTH CARE COSTS AND UTILIZATION.—

(1) APPLICATION.—The provisions of this subsection shall apply to changes in premiums for insured health benefit plans in the individual sector and the small group sector (as such terms are defined in subsection (d)(2)) that reflect increases in health care costs and utilization.

(2) EQUAL INCREASE FOR ALL PLANS WITHIN EACH SECTOR.—

(A) IN GENERAL.—To the extent that any increase in premiums by a health plan sponsor for insured health benefit plans reflect increases in health care costs and utilization—

(i) the annual percentage increase for plans within the individual sector shall be the same for all such plans in the sector; and

(ii) the annual percentage increase for plans within the small group sector shall be the same for all such plans in the sector.

(B) GEOGRAPHIC APPLICATION.—Subparagraph (A)—

(i) may be applied on a national level, or

(ii) may vary based on geographic area, but only if (I) such areas are sufficiently large to provide credible data on which to calculate the variation and (II) the variation is due to reasonable factors related to the objective differences among such areas in costs and utilization of health services.

(C) EXCEPTIONS TO ACCOMMODATE STATE RATE REFORM EFFORTS.—Subparagraph (A) shall not apply, in accordance with guidelines of the Secretary, to the extent necessary to permit a State to narrow the variations in premiums among insured health benefit plans offered by health plan sponsors to similarly situated groups or individuals within a sector.

(D) OTHER REASONS SPECIFIED BY THE SECRETARY.—The Secretary may specify through regulations such other exceptions to the provisions of this subsection as the Secretary determines are required to enhance stability of the health insurance market and continued availability of coverage.

(3) EVEN APPLICATION THROUGHOUT A YEAR.—In applying the provisions of this subsection to self-insured health benefit plans that are renewed in different months of a year, the annual percentage increase shall be applied in a consistent, even manner so that any variations in the rate of increase applied in consecutive months are even and continuous during the year.

(4) PETITION FOR EXCEPTION.—A health plan sponsor may petition the Secretary (or a State acting under a contract with the Secretary under subsection (a)(3)(C)) for an exception from the application of the provisions of this subsection. The Secretary may approve such an exception if—

(A) the sponsor demonstrates that the application of this subsection would threaten the financial viability of the sponsor, and

(B) the sponsor offers an alternative method for increasing premiums that is not substantially discriminatory to any sector or to any group or individual covered by an insured health benefit plan offered by the sponsor.

(f) MORE STRINGENT STATE LAWS NOT PREEMPTED.—The requirements of this subtitle do not preempt any State law unless State law directly conflicts with such requirements. The provision of additional protections under State law shall not be considered to directly conflict with such requirements.

(g) LIMIT ON CHANGES IN SELF-INSURED HEALTH BENEFIT PLANS.—

(1) IN GENERAL.—A sponsor of a self-insured health benefit plan may not make a modification of benefits described in paragraph (2).

(2) MODIFICATION OF BENEFITS DESCRIBED.—

(A) IN GENERAL.—A modification of benefits described in this paragraph is any reduction or limitation in coverage, effected on or after the effective date of this subtitle, with respect to any medical condition or course of treatment for which the anticipated cost for any individual enrollee is likely to exceed \$5,000 in any 12-month period.

(B) TREATMENT OF TERMINATION.—A modification of benefits includes the termination of a plan if the sponsor, within a period (specified by the Secretary) establishes a substitute plan that reflects the reduction or limitation described in subparagraph (A).

(3) REMEDY.—Any modification made in violation of this subsection shall not be effective and the sponsor of the self-insured health benefit plan shall continue to provide benefits as though the modification (described in paragraph (2)) had not occurred.

(h) DEFINITIONS.—In this subtitle:

(1) INCORPORATION OF DEFINITIONS UNDER SOCIAL SECURITY ACT.—The terms “carrier”, “health benefit plan”, “insured health benefit plan”, “self-insured health benefit plan”, and “sponsor” have the meaning given such terms in title XXII of the Social Security Act (as added by title V).

(2) OTHER TERMS.—

(A) COVERED EMPLOYEE.—The term “covered employee” means an employee (or dependent of such an employee) covered under a group health insurance plan.

(B) COVERED INDIVIDUAL.—The “covered individual” means, with respect to a health plan, an individual insured, enrolled, eligible for benefits, or otherwise covered under the plan.

(C) GROUP HEALTH INSURANCE PLAN.—

(i) IN GENERAL.—The term “group health insurance plan” means a health benefit plan offered primarily to employers for the purpose of providing health insurance to the employees (and dependents) of the employer.

(ii) INCLUSION OF ASSOCIATION PLANS AND MEWAS.—Such term includes—

(I) any arrangement in which coverage for health benefits is offered to employers through an association, trust, or other arrangement, and

(II) a multiple employer welfare arrangement (as defined in section 3(40) of the Employee Retirement Income Security Act of 1974), whether funded through insurance or otherwise.

(D) HEALTH PLAN SPONSOR.—The term “health plan sponsor” has the meaning given such term in section 2204(11) of the Social Security Act, as added by section 5001.

(E) INDIVIDUAL HEALTH INSURANCE PLAN.—

(i) IN GENERAL.—The term “individual health insurance plan” means any health benefit plan directly purchased by an individual or offered primarily to individuals (including families) for the purpose of permitting individuals (without regard to an employer contribution) to purchase health insurance coverage.

(ii) INCLUSION OF ASSOCIATION PLANS.—Such term includes any arrangement in which coverage for health benefits is offered to individuals through an association, trust, list-billing arrangement, or other arrangement in which the individual purchaser is primarily responsible for the payment of any premium associated with the contract.

(iii) TREATMENT OF CERTAIN ASSOCIATION PLANS.—In the case of a health benefit plan sponsored by an association, trust, or other arrange-

ment that provides health insurance coverage both to employers and to individuals, the plan shall be treated as—

(I) a group health insurance plan with respect to such employers, and

(II) an individual health insurance plan with respect to such individuals.

(F) STATE COMMISSIONER OF INSURANCE.—The term “State commissioner of insurance” includes a State superintendent of insurance.

(i) EFFECTIVE DATE.—

(1) INSURED HEALTH BENEFIT PLANS.—The provisions of this subtitle—

(A) shall first apply to insured health benefit plans provided in a State on or after January 1, 1995, except that subsection (b) shall apply to such plans on or after the date of the enactment of this Act; and

(B) shall not apply to an insured health benefit plan provided in a State on and after the first day of the first year during which the standards established by the Secretary under section 5001 for insured health benefit plans sold to individuals and employers are in effect in the State (in accordance with such section).

(2) SELF-INSURED HEALTH BENEFIT PLANS.—The provisions of this subtitle—

(A) shall first apply to self-insured health benefit plans provided on or after January 1, 1995, except that subsection (b) shall apply to such plans on or after the date of the enactment of this Act; and

(B) shall not apply as of the first day of the first year during which the standards established by the Secretary under section 5102 for self-insured health benefit plans and the sponsors of such plans are in effect.

Subtitle E—Health Alliances

SEC. 5401. HEALTH ALLIANCES.

Title XXII of the Social Security Act, as added by section 5001(a) and as amended by section 5201(c), is amended by adding at the end the following new part:

“PART E—PROMOTING HEALTH ALLIANCES

“Subpart 1—Grants for Establishment and Operation of Health Alliances

“SEC. 2261. ESTABLISHMENT OF GRANT PROGRAM.

“(a) IN GENERAL.—The Secretary shall establish a program under which the Secretary shall make grants to eligible States for the planning, development, and initial operation of regional health alliances meeting the requirements of section 2262.

“(b) ELIGIBILITY OF STATE.—A State is eligible to receive a grant under this subpart if the State submits to the Secretary (at such time and in such form as the Secretary may require) an application containing—

“(1) assurances that the State has established (or is in the process of establishing) one or more health alliances;

“(2) assurances that the State and each such alliance meet the applicable requirements of section 2262; and

“(3) such other information and assurances as the Secretary may require.

“(c) LIMIT ON TOTAL PROVIDED TO STATE.—The total amount of funds provided to a State under this subpart may not exceed \$5,000,000 for a 5-year period.

“(d) GRANTS TO CONTIGUOUS STATES ESTABLISHING JOINT ALLIANCE.—In the case of contiguous States each of which is eligible to receive a grant under this subpart, the Secretary may make grants to the States under this subpart for the establishment and operation of a health alliance operated jointly by the States and serving areas in each of the States.

“(e) EFFECT ON OTHER ALLIANCES ESTABLISHED BY STATES.—Nothing in this subpart shall preclude a State or any political subdivision in a State from establishing any health alliance for which the State does not receive a grant under this subpart, or preclude a State or any political subdivision of a State from establishing and operating such an alliance under terms and conditions other than those described in section 2262 for the health alliances of States receiving grants under this subpart.

“(f) ELIGIBILITY OF UNITS OF LOCAL GOVERNMENT.—A unit of local government may receive a grant under this part in the same manner as a State, except that the unit of local government is not eligible to receive a grant unless—

“(1) the geographic area over which the unit has jurisdiction is included in a metropolitan statistical area with a population not less than 1,000,000; and

"(2) the alliance established by the unit covers the entire geographic area over which the unit has jurisdiction.

"SEC. 2262. REQUIREMENTS FOR STATES AND HEALTH ALLIANCES.

"(a) **ESTABLISHMENT OF ALLIANCE BOUNDARIES AND SERVICE AREAS.**—In establishing the boundaries of a health alliance—

"(1) a State may not discriminate on the basis of or otherwise take into account race, age, gender, sexual orientation, language, religion, national origin, socio-economic status, or perceived health status; or

"(2) if an alliance area includes any portion of a metropolitan statistical area located in the State, the State shall include the entire portion of such metropolitan statistical area located in the State in the alliance area; and

"(3) if the State establishes more than one health alliance under this subsection—

"(A) no area of the State may be included in more than one alliance area, and

"(B) each area of the State shall be included in an alliance area.

"(b) **ORGANIZATION AND GOVERNANCE.**—A State may operate a health alliance through a State agency or a unit of local government or may contract with a non-profit organization for the operation of the alliance. The health alliance shall be governed by a Board of Directors whose members—

"(1) represent (in equal numbers) employers and consumers in the alliance service area;

"(2) do not represent health plans offered in the service area or providers furnishing health services in the area; and

"(3) are representative of the ethnic and racial composition of the population served by the alliance.

"(c) **OFFERING INSURED HEALTH BENEFIT PLANS.**—

"(1) **IN GENERAL.**—Each health alliance shall enter into a contract under this part with any carrier that seeks to offer a qualified health plan that is an insured health benefit plan under part B in the alliance's service area.

"(2) **APPLICATION OF PREMIUM RATES.**—The premium charged for enrollment in any insured health benefit plan offered by a carrier through a health alliance shall be determined in accordance with part B.

"(d) **SERVICES FOR EMPLOYERS.**—

"(1) **IN GENERAL.**—A health alliance shall offer to enter into agreements to provide the services described in paragraph (2) to any employer in the alliance area who is not an eligible sponsor of a self-insured health benefit plan under part B (without regard to whether or not the employer sponsors such a plan). Not later than one year after its establishment, a regional health alliance shall seek out and inform all such employers in the alliance area of the services available through the alliance.

"(2) **SERVICES DESCRIBED.**—The services provided by a health alliance to employers under paragraph (1) are—

"(A) the provision of information in a uniform format to each employee of such employers regarding the benefits offered by each qualified health plan offered through the alliance and the health benefit program under part A of title XXIII, including information on the premiums charged, the identity, location, qualifications, and availability of participating providers, and the number of individuals members enrolling and disenrolling from the plan in the most recent plan year;

"(B) the conducting of an annual open enrollment period and other activities to carry out the enrollment of employees of the employer in qualified health plans offered through the alliance, in accordance with the choice of plan made by the employee; and

"(C) the collection of premium contributions from employees and employers and the forwarding of such contributions to the plans in which the employees are enrolled.

"(3) **OPTIONAL ASSESSMENT OF FEE.**—A State may permit a health alliance to charge a fee to employers of up to two percent of premiums paid in exchange for the services provided, in accordance with standards established by of the Secretary.

"(e) **SERVICES ON BEHALF OF INDIVIDUALS EMPLOYED BY OTHER EMPLOYERS.**—The health alliance shall make services similar to those provided to employers under subsection (d) available to individuals who reside in the service area but are not employees of employers with whom the alliance provides the services described in such subsection.

"(f) ALLIANCE AS SOLE VENDOR OF QUALIFIED HEALTH PLANS.—A State receiving a grant under this subpart may provide that the health alliance shall be the exclusive vendor of qualified health plans in the State, but only if the alliance carries out such activities under a State benefit management program approved under subtitle B of title III of the Health Security Act.

"(g) FINANCIAL STANDARDS.—The health alliance shall meet standards established by the Secretary pertaining to the management of finances, maintenance of records, accounting practices, auditing procedures and financial reporting.

"(h) GRIEVANCES.—The health alliances shall establish procedures under which individuals enrolled in qualified health plans offered through the alliance may inform the alliance of complaints with the plans, and shall investigate each complaint with a qualified health plan brought to its attention.

"(i) COORDINATION OF ACTIVITIES WITH OTHER ALLIANCES.—A health alliance shall coordinate its activities with the activities of other health alliances in order to enroll in qualified health plans individuals who reside in the alliance service area but are employed by employers whose principal place of business is outside of the area.

"SEC. 2263. AUTHORIZATION OF APPROPRIATIONS.

"There are authorized to be appropriated \$150,000,000 for the 5-year period beginning with fiscal year 1995 for grants under this subpart.

"Subpart 2—Optional Use of Health Alliances to Carry Out Capital Allocation Plan

"SEC. 2271. CAPITAL ALLOCATION PLANS IN STATES RECEIVING GRANTS.

"(a) USE OF GRANT FOR OPERATION OF PLAN.—A State receiving a grant for the operation of a health alliance under subpart 1 may use funds provided under the grant for the operation of a capital allocation plan in the State by the alliance in a fiscal year if the Secretary approves the use of the grant for the operation of such a plan under subsection (b).

"(b) REQUIREMENTS FOR APPROVAL.—

"(1) IN GENERAL.—The Secretary shall approve the capital allocation plan of a State for a fiscal year if the Governor of the State provides the Secretary with information and assurances necessary for the Secretary to find that the plan meets the requirements of section 2272.

"(2) TERMINATION OR EXTENSION OF APPROVAL PERMITTED.—Notwithstanding paragraph (1), the Secretary may—

"(A) terminate the approval of a plan under this section for a fiscal year if the Secretary determines during the year that the plan is not substantially in compliance with section 2272; or

"(B) extend the approval of a plan under this section (on a conditional basis) for an additional period not to exceed 12 months.

"SEC. 2272. REQUIREMENTS FOR CAPITAL ALLOCATION PLANS.

"(a) IN GENERAL.—

"(1) OPERATION OF PLAN THROUGH HEALTH ALLIANCE.—A State's capital allocation plan meets the requirements of this section if—

"(A) the State designates the health alliances of the State under subpart 1 to enforce the plan in the alliance area;

"(B) all capital expenditures of health care services in the State "(except as provided in paragraph (2)) are subject to review and approval under the plan (in accordance with subsection (b));

"(C) the alliances determine whether capital expenditures are in accordance with the plan using the criteria specified in subsection (b) and notify the Secretary if it determines that any capital expenditures subject to the plan are not in accordance with the plan; and

"(D) the alliances provide the Secretary with assurances that the alliance is enforcing the plan.

"(2) SPECIAL TREATMENT OF SERVICES IN RURAL AREAS PERMITTED.—A capital allocation plan need not provide for review of expenditures for services provided in rural areas in a State if the State has developed a rural health plan in the same manner as a State rural health care plan developed pursuant to section 1820(b)(1)(A).

"(b) CONTENTS OF PLAN DESCRIBED.—

"(1) REQUIREMENTS RELATING TO ALLOCATION OF CAPITAL.—

"(A) IN GENERAL.—Each capital allocation plan under this subsection shall—

"(i) be developed consistent with criteria developed by the Secretary;

"(ii) be designed to assure that the needs of the State's residents for health care services are met;

"(iii) include occupancy targets for inpatient hospital facilities;

"(iv) include utilization targets for services subject to review under the plan; and

"(v) provide an opportunity for formal review and comment before becoming final.

"(B) SPECIFICS.—Each capital allocation plan must—

"(i) assure access to hospital facilities;

"(ii) identify where appropriate which facilities (and parts of facilities) would be consolidated in order to reach the occupancy and utilization targets for health care services;

"(iii) provide for regionalization of services, where appropriate; and

"(iv) address—

"(I) the special needs and circumstances of hospitals receiving an additional payment under section 1886(d)(5)(F), Federally-qualified health centers (as defined in section 1861(aa)(4)), and other institutions and facilities that receive special assistance for providing services to low-income individuals and other individuals in medically underserved communities (as defined in section 799(6) of the Public Health Service Act), and

"(II) the provision of trauma care.

"(2) REQUIREMENTS RELATING TO REVIEW.—

"(A) IN GENERAL.—The capital allocation plan shall—

"(i) require the review of any proposed expenditures for capital expenditures in excess of \$1,000,000 in the area covered by the plan;

"(ii) permit the review of expenditures in the area covered by the plan that are not described in clause (i); and

"(iii) provide that a review shall take into consideration at least the following criteria:

"(I) The relationship of the proposed capital expenditure to the plan.

"(II) The need that the population to be served has for the proposed services, equipment, or facility provided by the capital expenditure.

"(III) The availability of alternative, less costly, or more effective methods for providing such services.

"(IV) The impact of the proposed expenditure on the quality of care and the costs of health care services provided to such population.

"(V) The impact of the proposed expenditure on the utilization of the applicant's other capital resources.

"(VI) The extent to which the proposed services, equipment, or facility shall eliminate unnecessary or duplicative services.

"(VII) The extent to which the proposed services, equipment, or facility will be available to all residents of the area, regardless of their ability to pay for the use of such services, equipment, or facility.

"(B) SPECIAL RULES FOR DETERMINING AMOUNT OF EXPENDITURES.—In determining the amount of proposed expenditures for a capital project for purposes of subparagraph (A)(i), there shall be included—

"(i) the cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of the capital project with respect to which the expenditure is made; and

"(ii) any proposed expenditures for other capital projects which are found by the alliance to be fundamentally related to the capital project in question (in accordance with criteria developed by the State using guidelines established by the Secretary).

"(C) PROCEDURAL REQUIREMENTS.—The capital allocation plan shall meet requirements relating to procedures for review as follows:

"(i) Reviews must be performed under a regular schedule that provides that applications relating to expenditures for similar capital projects will be considered at the same time, and that provides an opportunity for additional applicants to seek approval for carrying out a capital project if the alliance determines (based on the application of an initial sponsor of such a project) that an expenditure for such a project would be appropriate under the plan.

"(ii) The determinations of the review must be made in public meetings.

"(iii) The alliance must make provision for access by the general public to all applications for review and for written findings of its reviews that state the basis for alliance determinations.

"(iv) The alliance must hold at least one public hearing if requested by persons directly affected by the review.

"(v) Any decision of the alliance to approve or not to approve a proposed capital expenditure must be based solely on the alliance's review and the record created by the review.

"(vi) An application for a proposed capital expenditure must include a timetable for completing the project for which the expenditure is proposed, and any approval of such an expenditure shall be withdrawn if the alliance finds that the applicant was not making a good faith effort to meet the timetable or to otherwise meet any applicable condition for approval.

"(vii) The allocation plan must provide either for an appeals mechanism (consistent with the State's administrative procedures act) or for an appeal before an entity (other than the alliance) designated by the Governor.

"(c) **DEFINITIONS.**—In this section:

"(1) The term "capital expenditure" means an expenditure which—

"(A) under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance; or

"(B) is made to obtain by lease or comparable arrangement any facility thereof or any equipment for a facility or part.

"(2) The term "rural area" has the meaning given such term in section 1886(d)(2)(D).

"SEC. 2273. LIMITING FEDERAL FINANCIAL PARTICIPATION FOR CAPITAL EXPENDITURES NOT APPROVED BY ALLIANCES.

In the case of a State receiving a grant under this subpart, the Secretary shall enter an agreement with the State under section 1122 under which the health alliance of the State shall be treated as a designated planning agency for purposes of such section."

TITLE VI—STANDBY COST CONTAINMENT IN THE PRIVATE SECTOR

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- Sec. 6313. Basis for other maximum payment rates for services using certain medicare payment methodologies.
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Subtitle E—Administrative and Judicial Review

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Subtitle F—National Health Cost Commission

Sec. 6501. National Health Cost Commission.

Sec. 6502. Expedited consideration of recommendations and alternatives.

Subtitle A—National Health Expenditure Estimates

SEC. 6001. NATIONAL PRIVATE SECTOR PER CAPITA HEALTH EXPENDITURE ESTIMATE.

(a) ESTABLISHMENT.—

(1) **IN GENERAL.**—For each calendar year (beginning with 1996), there is established a national private sector per capita health expenditure estimate (in this subtitle referred to as the “national private per capita estimate”) determined under paragraph (2).

(2) **AMOUNT.**—Subject to subsection (e)—

(A) 1996.—The national private per capita estimate for 1996 is equal to the private sector per capita budget baseline for 1995 (determined under subsection (b)) multiplied by the national private sector growth factor (specified under subsection (c)) for 1996.

(B) **SUBSEQUENT YEARS.**—The total amount of the national private per capita estimate for each year after 1996 is equal to the national private per capita estimate determined under this paragraph for the previous year multiplied by the national private sector growth factor (specified under subsection (c)) for the year involved.

(3) **PUBLICATION.**—The Secretary of Health and Human Services shall publish in the Federal Register and report to the Congress—

(A) by not later than April 1 before each year, an initial estimate of the national private per capita estimate for the year; and

(B) by not later than October 1 before each year, a final determination of the national private per capita estimate for such year.

(b) **PRIVATE SECTOR PER CAPITA BUDGET BASELINE.**—The Secretary shall compute a private sector per capita budget baseline under this subsection for 1995 as follows:

(1) **1993 ACTUAL EXPENDITURES.**—The Secretary shall determine (on the basis of the best data available) the amount of the private sector per capita expenditures (as determined under subsection (d)) for 1993.

(2) **PROJECTION FOR 1995.**—The Secretary shall increase such amount by the Secretary’s estimate of the percentage increase in the national private per capita estimate between the midpoint of 1993 and the midpoint of 1995.

(c) **NATIONAL PRIVATE SECTOR GROWTH FACTOR.**—The national private sector growth factor under this subsection for each year is 1 plus the sum (expressed as a fraction) of—

(1) the average annual percentage increase in the per capita gross domestic product (in current dollars, as published by the Secretary of Commerce) during the 5-year period ending with the second previous year; and

(2)(A) for 1996, 2.4 percentage points,

(B) for 1997, 0.6 percentage points, and

(C) for each year thereafter, 0 percentage points.

(d) **DETERMINATION OF NATIONAL PRIVATE PER CAPITA EXPENDITURES FOR 1993.**—

(1) **IN GENERAL.**—The Secretary shall determine for 1993 the national private per capita expenditures equal to—

(A) total covered health care expenditures (described in paragraph (2)), divided by

(B) the estimated average population in the United States of individuals in 1993 who are eligible individuals (and would be subject to the individual mandate in 1998) (other than medicare part A beneficiaries and individuals entitled to medical assistance under a State plan under title XIX of the Social Security Act) for whom such expenditures were determined.

(2) **COVERED HEALTH CARE EXPENDITURES.**—For purposes of paragraph (1)(A), the Secretary shall determine covered health care expenditures for 1993 as follows:

(A) **DETERMINATION OF TOTAL EXPENDITURES.**—

(i) **IN GENERAL.**—The Secretary shall first determine the amount of total payments made for items and services included in the guaranteed national benefit package (determined without regard to cost sharing) or included in any standard benefit package for supplemental health benefit policies established under part D of title XXII of the Social Security

Act (determined without regard to cost sharing) in the United States in 1993.

(ii) **INCLUSION OF ALL PAYERS.**—Except as provided in clause (iii), the amount of total payments described in clause (i) shall be determined without regard to the source of payment and shall include (as specified by the Secretary) direct patient expenditures and payments made by third party payers (including Government health programs and health maintenance organizations).

(iii) **EXCLUSIONS.**—In computing such payment amounts, there shall be excluded, as specified by the Secretary—

(I) nonoperating revenues (such as interest);

(II) receipts attributable to personal comfort and convenience items described in section 6002(a)(5);

(III) direct payments from the Federal Government, from State government, from units of local government for research to the extent unrelated (and not attributable) to the provision of health care services;

(IV) receipts attributable to the program for the provision of hospital care and medical services by the Department of Veterans' Affairs under chapter 17 of title 38, United States Code;

(V) payments made to health care facilities and providers of the Department of Defense and of the Indian Health Service; and

(VI) such other receipts unrelated to the provision of health care services as the Secretary specifies.

(B) **REMOVAL OF CERTAIN EXPENDITURES NOT INCLUDED IN PRIVATE SECTOR.**—The amount so determined shall be decreased by the proportion of such amount that is attributable to any of the following:

(i) Medicare beneficiaries.

(ii) Medicaid beneficiaries.

(iii) Expenditures which are paid for through workers' compensation or automobile or other liability insurance.

(iv) Expenditures which are paid for items and services excluded from classes of services under section 6002(a)(4).

(v) Expenditures by parties (including the Federal Government) that the Secretary determines will not be payable by private health plans for coverage either of the guaranteed national benefit package or under any supplemental health benefit policy under this Act.

(e) **ADJUSTMENTS.**—

(1) **IN GENERAL.**—Except as provided in this subsection, the Secretary is not authorized to adjust the national private per capita estimate for a year once it is published before October of the previous year.

(2) **RECOMMENDATIONS FOR CHANGES.**—Except as permitted under paragraphs (3) and (4), the Secretary may submit to Congress recommendations for changes in the national private per capita estimate, but may not implement such recommendations without the approval of Congress.

(3) **CORRECTION PERMITTED FOR ESTIMATION ERRORS IN PRIVATE SECTOR PER CAPITA BUDGET BASELINE.**—Insofar as the Secretary determines that the amounts used in estimating initially the private sector per capita budget baseline described in subsection (b) did not accurately reflect the actual amount described in subsection (b)(1) and the actual percentage increase described in subsection (b)(2), the Secretary shall adjust the national private per capita estimate to correct for such estimation errors.

(4) **SPECIAL RULE FOR 1998.**—The Secretary shall adjust the national private per capita estimate for 1998 in order to reflect the impact of universal coverage on the national private per capita estimate, including—

(A) the elimination from the private sector per capita budget baseline under subsection (b) of amounts attributable to uncompensated care or to a differential between payment rates under title XIX of the Social Security Act and payment rates in the private sector; and

(B) increased utilization of, and expenditures for, items and services covered under the guaranteed national benefit package likely to occur, as a result of coverage of individuals under qualified health plans who, as of 1997 were uninsured or underinsured with respect to such package.

(5) **SPECIAL RULE FOR YEARS AFTER 2002.**—The Secretary shall adjust the national private per capita estimate for each year after 2002 in order to reflect the impact of establishing an annual out-of-pocket limit on cost-sharing under the guaranteed national benefit package under section 2112 of the Social Security Act.

SEC. 6002. CLASSES OF HEALTH CARE SERVICES.

(a) ESTABLISHMENT OF CLASSES.—

(1) IN GENERAL.—

(A) SPECIFIED SERVICES.—

(i) **IN GENERAL.**—Subject to subparagraph (B)(ii), in the case of items and services specified in a subparagraph under paragraph (2), all of the items and services described in that subparagraph shall be considered to be a “separate” class of health care services.

(ii) **OVERLAPPING SERVICES.**—Except as the Secretary may provide, items and services specified in a subparagraph of paragraph (2) shall be considered to be excluded from the subsequent subparagraphs of that paragraph.

(B) OTHER ITEMS AND SERVICES.—

(i) **IN GENERAL.**—In the case of items and services included as health care services under paragraph (3), the Secretary shall group such items and services into such class or classes of health care services as may be appropriate.

(ii) **INCLUSION IN CLASSES OF SPECIFIED HEALTH CARE SERVICES.**—In carrying out clause (i), the Secretary may include an item or service described in paragraph (3) within a class of services established under subparagraph (A).

(iii) **UNIFORM DEFINITION OF CLASSES.**—The Secretary shall define classes under this section in a manner identical to the definition of classes under section 8202.

(2) SPECIFIED HEALTH CARE SERVICES.—Subject to paragraph (4), the items and services specified in this paragraph are as follows:

(A) Inpatient hospital services, other than mental health services.

(B) Outpatient hospital services and ambulatory facility services (including renal dialysis facility services), other than mental health services.

(C) Diagnostic testing services (including clinical laboratory services and x-ray services).

(D) Physicians’ services and other professional medical services, other than mental health services.

(E) Home health services and hospice care.

(F) Rehabilitation services, such as physical therapy, occupational and speech therapy.

(G) Durable medical equipment and supplies.

(H) Prescription drugs and biologicals and insulin.

(I) Nursing facility services, including skilled nursing facility services and intermediate care facility services, other than mental health services.

(J) Mental health services.

(3) CLASSIFICATION OF ADDITIONAL ITEMS AND SERVICES.—Subject to paragraph (4), with respect to items and services (not described in paragraph (2)) which are included under the guaranteed national benefit package or included in any standard benefit package for supplemental health benefit policies established under part D of title XXII of the Social Security Act, the Secretary may classify them either within a class specified in paragraph (2) or within a new class established by the Secretary for such an item or service.

(4) EXCLUSIONS.—The following items and services shall not be considered to be health care services and shall not be included in a class of services under paragraph (1) or (3):

(A) Over-the-counter medications and medical equipment and devices.

(B) Homemaker and home health aide services and personal care services, and other services described in section 1915(c)(4)(B), section 1929(a), or section 1930(a) of the Social Security Act.

(C) Inpatient mental health services of a custodial nature.

(5) EXCLUSION OF INSTITUTIONAL CHARGES FOR PERSONAL COMFORT AND CONVENIENCE ITEMS.—Payments received (and amounts charged) by a facility which are attributable to items (such as private rooms, telephones, and television rentals) provided for the personal comfort and convenience of patients shall not be counted as receipts (nor subject to limitations on amounts that may be charged) for purposes of this title.

(b) PUBLICATION.—

(1) IN GENERAL.—The Secretary shall publish—

(A) by not later than April 1, 1995, proposed regulations defining the health care services and establishing the classes of services under this section, and

(B) by not later than October 1, 1995, final regulations defining the health care services and establishing such classes.

(2) ITEMS INCLUDED IN REGULATIONS.—In such regulations, the Secretary shall define—

(A) the class or classes to be established under subsection (a)(1),

(B) the services to be included within each class, and

(C) the methods and sources of data for computing, for purposes of this title, the national private per capita estimate within the class.

(3) CHANGES.—

(A) NO CHANGES AUTHORIZED.—After the Secretary has established classes of services under paragraph (1)(B), the Secretary may not change such classes (or the services included in such classes), except in the case of services not previously classified. Any such services not previously classified shall be classified within one of the classes previously established.

(B) RECOMMENDED CHANGES.—If the Secretary determines that a change in the classification established under this section may be appropriate, the Secretary shall submit to the Congress a report proposing such change. The Secretary shall include in the report an explanation of—

(i) the rationale for such change, and

(ii) the impact of such change on the national private per capita estimate permitted for classes of services that would be affected by the change.

(4) COMMISSION REPORTS.—

(A) INITIAL REPORTS.—With respect to the establishment of classes of services under this section, each applicable Commission (as defined in section 8202(c)), by not later than June 1, 1995, shall report to the Congress its comments concerning the classification proposed by the Secretary under paragraph (1)(A).

(B) PERIODIC REPORTS.—Each applicable Commission shall periodically report to Congress on changes in the system of classification under this section that should be made to promote the more efficient provision of medically appropriate health care services.

(c) APPLICABLE COMMISSION DEFINED.—In this title, the term “applicable Commission” has the meaning given such term in section 8202(c).

SEC. 6003. ALLOCATION OF PER CAPITA ESTIMATES BY CLASS OF SERVICE.

(a) ALLOCATION.—

(1) IN GENERAL.—The Secretary shall allocate the national private per capita estimate under section 6001 for a year among classes of services specified under section 6002.

(2) PROPORTIONAL ALLOCATION BASED ON HISTORICAL PROJECTED EXPENDITURES.—

(A) IN GENERAL.—The amount allocated to each class for a year shall be equal to the national private per capita estimate allocated for the year multiplied by the ratio (expressed as a percentage) of—

(i) the historical projected private expenditures for the class for the year (as determined under subsection (b)(2)), to

(ii) the sum of such historical projected private expenditures for all the classes for the year.

(B) NATIONAL ANNUAL RATE OF INCREASE FOR A CLASS OF SERVICES.—In this Act, the term “national annual rate of increase” means, with respect to a class of services for a year, the percentage by which—

(i) the amount determined under subparagraph (A) for the class for the year, exceeds

(ii) the amount determined under such subparagraph for the class for the preceding year.

(3) PUBLICATION.—

(A) IN GENERAL.—The Secretary shall, in conjunction with the publication of the initial estimate and final determination of the national private per capita estimate under section 6001(a)(3) for a year, publish in the Federal Register and report to the Congress the allocation of the national private per capita estimate among the classes of services under this subsection.

(B) EXCEPTION FOR 1996.—For 1996, the Secretary shall publish and report the allocation of the national private per capita estimate among the classes of services under this subsection not later than August 1, 1995.

(b) HISTORICAL PROJECTED PRIVATE EXPENDITURES.—

(1) IN GENERAL.—

(A) DETERMINATION.—For purposes of subsection (a)—

(i) FOR 1995.—The historical projected private expenditures for a class of services for 1995 is equal to the portion of the national private per capita estimate during 1993 (as determined under section 6001(b)(2)(A)) which is attributable to the class of services, multiplied by the private trend factor (described in subparagraph (B)) for the class for 1995. In computing such portion for classes, the Secretary shall take into account the allocation of expenditures by health maintenance organizations among the different classes of services.

(ii) SUBSEQUENT YEARS.—The historical projected private expenditures for a class of services for a year after 1995 is equal to the amount of the allocation for the class under subsection (a)(2)(B) for the preceding year multiplied by the trend factor (described in subparagraph (B)) for the class for the year involved and multiplied by the adjustment factor described in subparagraph (C) for the year.

(B) PRIVATE TREND FACTOR.—In subparagraph (A), the “private trend factor”, for a class of services, is 1 plus the average annual rate of increase in per capita private expenditures for the class of services during the 5-year period ending with 1995.

(C) ADJUSTMENT FACTOR.—The adjustment factor described in this subparagraph for a year is equal to the ratio of—

(i) the national private per capita estimate for the year (as determined under section 6001(a)(2)), or, for 1995, the private sector per capita budget baseline for 1995 (as determined under section 6001(b)(2)), to

(ii) the sum of the historical projected private expenditures projected for all the classes for the year (determined under subparagraph (A) without regard to this subparagraph).

(2) PUBLICATION OF TREND FACTORS.—The Secretary shall publish, by not later than August 1, 1995, the private trend factors for the different classes of services.

(c) REVIEW AND CHANGES IN ALLOCATION.—

(1) IN GENERAL.—

(A) NO ADMINISTRATIVE AUTHORITY TO CHANGE.—Except as specifically provided in this paragraph or by law enacted after the enactment of this Act, the Secretary has no authority to change the allocation or private trend factors from the allocation and private trend factors provided under this section.

(B) RECOMMENDED CHANGES.—Subject to subparagraph (C), if the Secretary determines that a change in the allocation of an estimate among classes is appropriate, the Secretary shall submit to the Congress a report proposing such change. The Secretary shall include in the report an explanation of—

(i) the rationale for such change, and

(ii) the impact of such change on the national private per capita estimate permitted for classes of services that would be affected by the change.

(C) CORRECTION PERMITTED FOR ESTIMATION ERRORS.—Insofar as the Secretary determines that the amounts used in estimating initially the historical projected private expenditures under this subsection did not accurately reflect the actual portions described in subsection (b)(1)(A)(i) or the actual private trend factors described in subsection (b)(1)(B), the Secretary shall adjust the allocation of the national private per capita estimate among classes of services to correct for such estimation errors.

(2) COMMISSION REVIEW.—Each applicable Commission shall annually review and report to Congress, in its report submitted under section 6002(b)(4), on the effect of the private trend factors used in the allocation of the national private per capita estimate among classes of services. Such report shall include such recommendations for appropriate adjustments in the private trend factors as the applicable Commission considers appropriate to properly take into account at least—

(A) changes in health care technology,

(B) changes in the patterns and practices relating to health care delivery found to be appropriate,

(C) changes in the distribution of health care services, and

(D) the special health care needs of underserved rural and inner city populations.

SEC. 6004. NATIONAL HEALTH EXPENDITURES REPORTING SYSTEM.

(a) **IN GENERAL.**—The Secretary shall establish a national health expenditures reporting system (in this section referred to as the “system”) for purposes of—

- (1) establishing the national private per capita estimate,
- (2) allocating the national private per capita estimate among classes of services,
- (3) determining maximum payment rates,
- (4) monitoring of any State cost containment and benefit management programs established by States pursuant to title IV, and
- (5) otherwise carrying out this title.

(b) **INFORMATION REPORTING.**—

(1) **ANNUAL REPORT BY PROVIDERS.**—

(A) **IN GENERAL.**—Under the system, providers of health care services (including such providers within provider networks) shall submit (by not later than April 15 of each year, beginning with 1997) a report.

(B) **CONTENTS.**—Such a report shall include such information as the Secretary specifies relating to the provision of health care services in the previous year, including—

- (i) the volume and receipts for such services,
- (ii) cost and revenue data for hospitals and other institutional providers and revenue data for other providers, and
- (iii) information by class of service, type of payer, and State of residence of individual provided the services.

Information on revenues for activities not related to the provision of direct patient care, such as teaching or research or for services that are explicitly excluded from the system of national health expenditures estimates, shall be reported separately.

(C) **FORM.**—The report shall be submitted in such form and manner (including the use of electronic transmission) as the Secretary shall specify in regulation. Such form shall permit the reporting of information by health plans on behalf of providers who are in provider networks in the plan.

(D) **USE OF REPORTING MECHANISMS.**—To the maximum extent practicable and appropriate, reporting under such system shall be done through reporting mechanisms (such as uniform hospital reports provided under section 9105) and using data bases otherwise in use.

(E) **USE OF SURVEYS.**—The Secretary may, where appropriate, provide for the collection of information under the system through surveys of a sample of health care providers or with respect to a sample of information with respect to such providers.

(2) **CONFIDENTIALITY.**—Information gathered pursuant to the authority provided under this section shall not be disclosed in a manner that identifies individual providers of services.

(3) **TRANSITION.**—Before April 15, 1997, for purposes of this title, the Secretary may use such other data collection and estimation techniques as may be appropriate for purposes described in subsection (a).

(c) **ENFORCEMENT.**—If a provider of health services is required, under the system under this section, to report information and refuses, after being requested by the Secretary, to provide the information required, or deliberately provides information that is false, the Secretary may impose a civil money penalty of not to exceed \$10,000 for each such refusal or provision of false information. The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply to civil money penalties under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

Subtitle B—State Health Expenditure Estimates

SEC. 6101. STATE PRIVATE SECTOR PER CAPITA HEALTH EXPENDITURE ESTIMATE.

(a) **ESTABLISHMENT.**—

(1) **IN GENERAL.**—For each calendar year (beginning with 1996), the Secretary shall establish a State private sector per capita health expenditure estimate (in this title referred to as a “State private per capita estimate”) for each State under paragraph (2).

(2) **AMOUNT.**—Subject to subsection (e), the State private per capita estimate for a State for a year is equal to the national private per capita estimate for the year, established under section 6001, multiplied by the applicable State adjustment factor (specified under subsection (b)) for the State.

(3) PUBLICATION.—The Secretary shall publish in the Federal Register and report to the Congress and to each State—

(A) by not later than April 1 before each year, an initial estimate of the State private per capita estimate for each State for the year; and

(B) by not later than October 1 before each year, a final determination of the State private per capita estimate for each State for the year.

(4) PERIODIC COMMISSION REPORTS ON STATE ESTIMATES.—Each applicable Commission shall periodically review and report to Congress on the State private per capita estimates established under this section. Such a report shall include such recommendations as the respective Commission deems appropriate.

(b) STATE ADJUSTMENT FACTORS.—

(1) IN GENERAL.—The Secretary shall compute a State adjustment factor for each State consistent with this subsection.

(2) UTILIZATION AND PRICE FACTORS.—In establishing State adjustment factors, the Secretary shall take into account the following:

(A) RATIO OF STATE PRIVATE SECTOR PER CAPITA EXPENDITURES TO NATIONAL PRIVATE SECTOR PER CAPITA EXPENDITURES.—Subject to adjustments to reflect subparagraphs (B) and (C), the ratio of a State private sector per capita expenditures (that would be computed for the State under section 6001(d) if computations under such section were made for that State rather than for the United States) to the national private per capita expenditures determined under such section.

(B) HISTORIC UTILIZATION.—With respect to utilization of services, differences among the States in demographic composition and historic utilization of different services in the private sector in 1993.

(C) MAXIMUM PAYMENT RATES UNDER THIS TITLE.—With respect to the price of services, the price of such services that would be allowed in the State in 1995 if the maximum payment rates (provided under subtitle D) were to apply in the State in 1995.

(3) ADJUSTMENT TO REFLECT HEALTH CARE EXPENDITURES FOR STATE RESIDENTS.—The Secretary shall provide for an adjustment to take into account differences among States in the in-State, and out-of-State, use of services by residents and non-residents of the State, in order that the per capita amount reflects per capita health care expenditures for residents of the State for services provided anywhere in the United States.

(4) AVERAGE.—The Secretary shall establish the State adjustment factors in such a manner as assures that the population weighted average of such factors is 1.

(c) ADJUSTMENT.—

(1) IN GENERAL.—Subject to paragraph (3), the provisions of section 6001(e) shall apply to the State private per capita estimates under this section in the same manner as they apply to the national private per capita estimate.

(2) ADJUSTMENT TO CORRECT ESTIMATION ERRORS.—Insofar as the Secretary determines that the amounts used in estimating initially the State private per capita estimates did not accurately reflect the correct values for the factors used in computing State adjustments factors under subsection (b), the Secretary shall adjust the State private per capita estimates to correct for such estimation errors.

(3) ADJUSTMENT IN 1998.—In applying section 6001(e)(4) under paragraph (1), the adjustment for each State private per capita estimate shall be the same as the adjustment to the national private per capita estimate under such section.

Subtitle C—Stand-By Federal Cost Containment

SEC. 6201. APPLICATION OF MAXIMUM PAYMENT RATES IN STATES THAT FAIL TO CONTROL COSTS.

(a) DETERMINATION OF STATE PERFORMANCE.—

(1) IN GENERAL.—During each year (beginning with 1997), the Secretary shall determine for each State whether the actual State private per capita health care expenditures (determined in a manner similar to the manner in which the national private per capita expenditures is determined under section 6001(d)(2)) for the previous year exceeded the State private per capita estimate for the State for such year (as determined under subtitle B). Such determination shall be based on information submitted by providers under section 6005 and such other data as the Secretary finds appropriate.

(2) ADJUSTMENT OF ACTUAL PER CAPITA HEALTH EXPENDITURES.—

(A) IN GENERAL.—In accordance with procedures established by the Secretary, a State may apply to the Secretary to exclude from the computation of actual State per capita health expenditures under paragraph (1) in the State for a year expenditures attributable to health care needs of a sudden and temporary nature, such as epidemics or natural disasters, to the extent that health care expenditures for such or similar needs were not reflected in the State private per capita estimate.

(B) LIMITATION.—For purposes of subparagraph (A), expenditures extending over a period of longer than 6 months shall not be considered temporary.

(b) APPLICATION OF STANDBY COST CONTAINMENT UNDER SUBTITLE D.—

(1) IN GENERAL.—If the Secretary determines in a year under subsection (a) beginning after 1999 that the actual State per capita health expenditures in a State for the previous year was greater than the State private per capita estimate for the State for such year, subject to paragraph (2) the provisions of subtitle D shall apply to charges imposed (and payments made) for services furnished in the State on or after January 1 of the following year.

(2) SUBSTITUTION OF STATE APPROVED ALTERNATIVE PAYMENT SYSTEM.—

(A) ALTERNATIVE PAYMENT SYSTEM.—Subtitle D shall not apply in a State for a year to services if the Secretary determines that the State has in effect for the year an alternative payment system that meets the applicable requirements of subtitle A of title III for the services covered.

(B) BENEFITS MANAGEMENT PROGRAM.—Subtitle D shall not apply in a State for a year if the Secretary determines that the State has in effect for the year a benefits management program that meets the applicable requirements of subtitle B of title III.

Subtitle D—Maximum Payment Rates

PART 1—ESTABLISHMENT AND APPLICATION OF MAXIMUM PAYMENT RATES

SEC. 6301. PROCESS.

(a) PUBLICATION OF RATES.—

(1) IN GENERAL.—The Secretary shall cause to have published in the Federal Register—

(A) not later than April 1 of each year (or not later than September 1, 1995, in the case of rates for 1996), proposed maximum payment rates under this subtitle for the following year for public comment, and

(B) not later than October 1 of each year (or not later than December 1, 1995, in the case of rates for 1996), after such consideration of public comment on the proposed rates, the maximum payment rates under this subtitle for the following year.

(2) PAYMENT RATES ONLY ADVISORY FOR 1996 THROUGH 2000.—The maximum payment rates for 1996 through 2000 published under paragraph (1) are only advisory and shall not be applied to payment for services during such years.

(b) ITEMS INCLUDED IN PUBLICATIONS.—The Secretary shall include in the publications referred to in subsection (a)(1)—

(1) a description of the payment methodology used in the establishment of maximum payment rates; and

(2) in the case of a publication under subsection (a)(1)(B), the extent that the rates differ from the applicable Commission's recommendations under subsection (c), an explanation of the Secretary's grounds for not following such recommendations.

(c) REPORTS OF COMMISSIONS.—With respect to the establishment of maximum payment rates for services under this subtitle, the applicable Commission, not later than June 1 of each year, shall report its recommendations to the Secretary and Congress concerning such rates for the following year. Each such report may include such other recommendations relating to the operation of this subtitle as the Commission considers appropriate.

(d) PAYMENT RATE DEFINED.—In this subtitle, the term "payment rate" means, with respect to health care services for which amounts are payable under a plan or program, the rate of payment provided for under the plan or program and including cost-sharing (including deductibles, coinsurance, and extra billing amounts) applicable under the plan or program with respect to the services.

SEC. 6302. PAYMENT METHODOLOGY; RELATION TO ESTIMATE ALLOCATION.

(a) PAYMENT METHODOLOGY.—

(1) IN GENERAL.—Subject to sections 8002(c) and 8003, the Secretary shall establish maximum payment rates under this subtitle consistent with the payment rate methodology specified under part 2.

(2) TREATMENT OF SERVICES WITHIN A CLASS.—Nothing in this title shall be construed as requiring that maximum payment rates established under this subtitle for different health care services within a class of services be the same or determined under the same methodology.

(b) RELATION TO NATIONAL PRIVATE PER CAPITA ESTIMATE.—

(1) IN GENERAL.—Subject to paragraph (2), the maximum payment rates for a year shall be established under this subtitle in a manner so that, if they were to apply in the year in all the States under this title—

(A) the national average private per capita expenditures for all the services within each class subject to such rates, is equal to

(B) the percent of the national private per capita estimate allocated to the class under section 6003(a)(1) for the year.

(2) RULES FOR CERTAIN STATES.—The rates shall be established under paragraph (1) not taking into account any reductions in such rates effected under section 4004(c)(2)(A). The reductions under such section shall be applied only to the rates (as so established) in that State.

SEC. 6303. GENERAL APPLICATION AND ENFORCEMENT OF MAXIMUM PAYMENT RATES.

(a) LIMITS ON CHARGES.—

(1) IN GENERAL.—In the case of a provider that provides health care services to an individual for which a maximum payment rate is established and applied pursuant to this subtitle and subtitle C—

(A) the provider may not charge (i) an amount in excess of such rate or (ii) on a payment basis other than the payment basis established for such services under part 2;

(B) the provider may not collect for such services an amount in excess of such rate; and

(C) the individual and other entities, including a health benefit plan, are not liable collectively for payment of any amount that exceeds such rate.

(2) RELATION TO MEDICARE PROGRAMS.—This subsection shall not apply to services furnished to an individual who is entitled to benefits with respect to such services under title XVIII or under part A or subpart 2 of part B of XXIII of the Social Security Act.

(b) ENFORCEMENT THROUGH CIVIL MONEY PENALTIES.—

(1) IMPROPER CHARGES.—If a provider imposes a charge in violation of subsection (a)(1)(A), the provider is subject to civil money penalty in an amount not to exceed \$100 for each such charge.

(2) IMPROPER COLLECTION.—If a provider collects excess amounts in violation of subsection (a)(1)(B) and does not refund such excess amounts within 30 days of date on which the provider is notified (in a form and manner specified by the Secretary) that the provider collected excess amount, the provider is subject to a civil money penalty in an amount equal to three times the amount of such excess which has not been so refunded or, if greater, \$500.

(3) PROCESS.—The provisions of section 1128A of the Social Security Act (other subsections (a) and (b)) shall apply to a civil money penalty under this subsection in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(4) DEPOSIT OF PENALTIES IN ALL-PAYER HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.—Any civil money penalties collected under this subsection shall be paid into the All-payer Health Care Fraud and Abuse Control Account (established under section 9212).

SEC. 6304. LIMITS ON PAYMENTS BY PROPERTY AND CASUALTY INSURERS FOR SERVICES.

(a) IN GENERAL.—Without regard to whether the maximum payment rates are established and applied pursuant to this subtitle and subtitle C in a State, the fees for medical services which are covered by property or casualty insurance shall not be less favorable than the fees for similar services covered by the health benefit plan in which the individual is enrolled, without regard to cost-sharing that might otherwise be applicable under the health plan.

(b) EFFECTIVE DATE.—Subsection (a) shall apply to medical services furnished on or after January 1, 1998.

PART 2—METHODOLOGIES FOR DETERMINING MAXIMUM PAYMENT RATES

SEC. 6311. BASIS FOR MAXIMUM PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES.

(a) PAYMENT RATES.—

(1) **IN GENERAL.**—Subject to subsection (e), the maximum payment rate established under this subtitle for a service within the class of services consisting of inpatient hospital services that is provided by—

(A) a hospital that is not an exempt hospital (as defined in paragraph (4)) is the payment rate specified in paragraph (2), or

(B) an exempt hospital is the payment rate specified in paragraph (3).

(2) **RATE FOR GENERAL HOSPITALS.**—The payment rate under this paragraph during a year shall be equal to the sum of the following:

(A) **STANDARD DRG-BASED PAYMENT RATE.**—The product of—

(i) the standardized amount applicable to the hospital, as established in accordance with subsection (b), adjusted under subsection (d); and

(ii) the weighting factor assigned to the service (as determined in accordance with subsection (c)).

(B) **OUTLIERS.**—An amount for discharges classified as outliers, in accordance with a methodology similar to the methodology used under section 1886(d)(5)(A) of the Social Security Act.

(C) **DIRECT GRADUATE MEDICAL EDUCATION.**—An amount for direct graduate medical education costs of the hospital, as determined in accordance with subtitle B of title VII.

(3) **RATE FOR EXEMPT HOSPITALS.**—The payment rate under this paragraph during a year shall be determined on a per admission basis, based on the allowable operating receipts of the hospital (determined in the manner specified in subparagraphs (A) and (B) of subsection (b)(2)).

(4) **EXEMPT HOSPITAL DEFINED.**—In this section, the term “exempt hospital” means—

(A) a psychiatric hospital (as defined in section 1861(f) of the Social Security Act), including a psychiatric unit of a hospital which is a distinct part of the hospital (as defined by the Secretary);

(B) a rehabilitation hospital (as defined by the Secretary), including a rehabilitation unit of a hospital which is a distinct part of the hospital (as defined by the Secretary);

(C) a hospital whose inpatients are predominantly individuals under 18 years of age;

(D) a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days; or

(E) a hospital that the Secretary has classified, at any time on or before December 31, 1990, for purposes of applying exceptions and adjustments to payment amounts under section 1886(d) of such Act, as a hospital involved extensively in treatment for or research on cancer.

(5) **EXCLUSION OF EXEMPT HOSPITALS IN DETERMINATIONS.**—For purposes of the succeeding subsections of this section, the term “hospital” does not include an exempt hospital.

(b) **ESTABLISHMENT OF STANDARDIZED AMOUNTS.**—

(1) **IN GENERAL.**—The Secretary shall establish a standardized amount under subsection (a) for hospitals located in a large urban area and for other hospitals for a year by standardizing the hospital's average cost per discharge (based on the hospital's allowed operating receipts, as determined under paragraph (2)) in accordance with paragraph (3). For purposes of the preceding sentence, a hospital is located in a “large urban area” if the hospital is treated as being located in a large urban area under section 1886(d) of the Social Security Act for purposes of the medicare program.

(2) **ALLOWED OPERATING RECEIPTS PER DISCHARGE DEFINED.**—

(A) **IN GENERAL.**—For purposes of paragraph (1) and except as provided in subparagraph (B), a hospital's “allowed operating receipts” means the total of all receipts of the hospital (without regard to the source) attributable to routine operating costs, ancillary service operating costs, and special care unit operating costs with respect to inpatient hospital services, as determined on an average per admission or per discharge basis (as determined by the Secretary), during 1993, increased by the Secretary's estimate of the percentage increase in such receipts between the midpoint of 1993 and the midpoint of 1995.

(B) **EXCLUSIONS.**—In determining a hospital's allowed operating receipts per discharge under subparagraph (A), the Secretary shall exclude receipts attributable to services for which payment was made to the hospital under the medicare program and discharges (or admissions) attributable to individuals entitled to benefits under part A of the medicare program.

(C) **CERTAIN OUTPATIENT RECEIPTS INCLUDED.**—In determining a hospital's allowed operating receipts under subparagraph (A), the Secretary

shall include all receipts attributable to services that are provided by the hospital (or by an entity wholly owned or operated by the hospital) to a patient during the 3 days immediately preceding the date of the patient's admission if such services are diagnostic services (including clinical diagnostic laboratory tests) or are other services related to the admission (as defined by the Secretary).

(3) **PROCESS FOR STANDARDIZING AMOUNTS.**—The Secretary shall standardize the average per discharge amount for each hospital for a year, in a manner similar to the standardization process described in section 1886(d)(2)(C) of the Social Security Act, by providing for the following adjustments and exclusions:

(A) Adjusting for variations among hospitals by area in the average hospital wage level, using the area wage level applied for hospitals under the medicare program under section 1886(d)(3)(E) of the Social Security Act.

(B) Adjusting for variations in case mix among hospitals.

(C) Excluding an estimate of the additional payments to be made for outliers, using the amounts paid to hospitals for outliers under the medicare program under section 1886(d)(5)(A) of such Act (except that the Secretary may apply different amounts if the Secretary finds that such different amounts more accurately reflect outliers for services furnished to individuals who are not medicare beneficiaries).

(D) Adjusting for variations among hospitals by area in input prices other than wages and wage-related costs.;

(E) Excluding an estimate of indirect medical education costs, using the indirect medical education adjustment applied for hospitals under the medicare program under section 1886(d)(5)(B) of such Act.

(F) Excluding an estimate of the additional payments made for hospitals serving a disproportionate share of low-income individuals, determined in the same manner as payment adjustments made on behalf of such hospitals under section 1886(d)(5)(F) of such Act (as amended by this Act).

(G) Excluding an estimate of direct graduate medical education costs.

(H) Excluding an estimate of capital-related costs.

(c) **ESTABLISHMENT OF DIAGNOSIS-RELATED GROUPS AND WEIGHTING FACTORS.**—

(1) **DIAGNOSIS-RELATED GROUPS.**—For purposes of this section, the Secretary shall establish a classification of inpatient hospital discharges by diagnosis-related groups and a methodology for classifying specific hospital discharges within these groups.

(2) **WEIGHTING FACTORS.**—For each diagnosis-related group established under paragraph (1), the Secretary shall assign an appropriate weighting factor which reflects the relative hospital resources used with respect to discharges classified within that group compared to discharges classified within other groups.

(3) **USE OF MEDICARE GROUPS AND FACTORS.**—In establishing diagnosis-related groups and assigning weighting factors for such groups under this paragraph, the Secretary shall use the diagnosis-related groups and weighting factors used under the medicare program under section 1886(d)(4) of the Social Security Act, except to the extent that the Secretary must establish diagnosis-related groups in addition to the groups under such program, or adjust such weighting factors, to take into account the application of payment rates under this section to inpatient hospital services furnished to individuals who are not medicare beneficiaries. In carrying out this paragraph, the Secretary shall establish separate diagnosis-related groups and weighting factors applicable to services furnished to children.

(d) **ADJUSTMENTS TO STANDARDIZED AMOUNTS.**—The adjustments under this subsection are as follows:

(1) **WAGE ADJUSTMENT.**—Adjusting for variations among hospitals by area in the average hospital wage level, using the area wage level applied for hospitals under the medicare program under section 1886(d)(3)(E) of the Social Security Act.

(2) **NON-WAGE ADJUSTMENT.**—Adjusting for variations among hospitals by area in input prices other than wages and wage-related costs.

(3) **ADDITION OF INDIRECT MEDICAL EDUCATION.**—Adding an amount for the indirect medical education costs of the hospital, in accordance with subtitle B of title VII.

(4) **ADDITION OF CAPITAL.**—Adding an amount for capital and capital-related costs, determined in the same manner as payment for such costs is provided under section 1886(g) of the Social Security Act.

(5) **ADDITION OF DSH.**—Adding an amount in the case of hospitals serving a disproportionate share of low-income individuals, determined in the same man-

ner as payment adjustments are made on behalf of such hospitals under section 1886(d)(5)(F) of such Act (as amended by this Act).

(e) OTHER ADJUSTMENTS.—

(1) NEEDS OF CERTAIN FACILITIES.—The Secretary may adjust the maximum payment rates otherwise determined under this section for hospitals in such manner and to such extent as the Secretary considers appropriate to take into account the needs of—

(A) regional and national referral centers described in section 1886(d)(5)(C) of the Social Security Act;

(B) sole community hospitals described in section 1886(d)(5)(D) of such Act; and

(C) essential access hospitals designated by the Secretary under section 1820(i)(1) of such Act.

(2) RULES FOR TRANSFERRED PATIENTS.—The Secretary shall provide for rules for applying the maximum payment rates under this section in the case of a hospital for inpatient hospital services provided to patients transferred to (or from) the hospital, in accordance with the rules used with respect to such transfers under the medicare program.

SEC. 6312. BASIS FOR MAXIMUM PAYMENT RATES FOR CLASS OF PHYSICIANS' SERVICES AND OTHER PROFESSIONAL MEDICAL SERVICES.

(a) USE OF RELATIVE VALUE FEE SCHEDULE.—

(1) IN GENERAL.—Subject to subsection (b), the maximum payment rates established under this subtitle for a service within the class of services consisting of physicians' services and other professional medical services during a year shall be equal to the product of—

(A) the relative value for the service applied under section 1848(b) of the Social Security Act;

(B) an applicable conversion factor (determined by the Secretary in an amount consistent with the requirements of section 6302(b)); and

(C) the applicable geographic adjustment factors applied under section 1848(b) of the Social Security Act.

(b) NEW PROCEDURE CODES AND RELATIVE VALUE UNITS.—In applying subsection (a) in the case of services for which relative value units have not been established under section 1848 of the Social Security Act, the Secretary shall establish relative value units in the same manner as if payment for such services were made under the medicare program.

(c) PUBLICATION OF DEFINITIONS, RELATIVE VALUE UNITS, AND PAYMENT POLICIES.—The Secretary shall provide for publication of such definitions, relative value units (established under subsection (b)), and payment policies as may be necessary for payers to apply the maximum payment rates established under this section.

SEC. 6313. BASIS FOR OTHER MAXIMUM PAYMENT RATES FOR SERVICES USING CERTAIN MEDICARE PAYMENT METHODOLOGIES.

The maximum payment rates established under this subtitle for services for any of the following classes of services shall be determined using the applicable payment methodologies under the medicare program as follows:

(1) In the case of facility services described in section 1832(a)(2)(F) of the Social Security Act furnished in connection with a surgical procedure specified pursuant to section 1833(i)(1)(A) of such Act and furnished to an individual in an ambulatory surgical center described in such section, the methodology described in section 1833(i)(2) of such Act.

(2) For services provided by Federally qualified health centers, the methodology shall be the cost-based methodology used in determining payment amounts under the medicare programs, as amended by section 7022, and the maximum payment rates shall be the amounts determined under such programs.

(3) For the class of diagnostic testing services described in section 6002(a)(2)(C)—

(A) in the case of clinical laboratory services, the methodology described in sections 1833(a)(2)(D) and 1833(h) of such Act (including the requirement of direct billing for such services), and

(B) in the case of other diagnostic services, the applicable methodology under part B of title XVIII of the Social Security Act.

(4) In the case of an item of durable medical equipment (described in section 1834(a)(13) of the Social Security Act), the methodology described in section 1834(a)(1) of such Act.

(5) In the case of prosthetic devices and orthotics and prosthetics, the methodology described in section 1834(h)(1)(A) of the Social Security Act.

(6) In the case of psychologists and clinical social workers, the methodologies described in section 1833(a)(1)(L) and 1833(a)(1)(F) of the Social Security Act, respectively.

(7) For prescription drugs, the methodology used to determine payment limits under section 1834(d)(4) of the Social Security Act, as inserted by section 3102(a), except that—

(A) any reference in such section to “1998” or “1999” shall be deemed to be a reference to “1996” or “1997”,

(B) any reference in such section to “4 12-month periods ending with June 1997” shall be deemed a reference to “2 12-month periods ending with June 1995”, and

(C) any reference in such section to the uniform percentage increase determined under section 8206(a) shall be deemed a reference to national rate of increase for the class of prescription drugs established under 6003(a)(2)(B).

(8) For renal dialysis services, home dialysis supplies and equipment (as defined in section 1881(b)(8) of the Social Security Act), and self-care home dialysis support services (as defined in section 1881(b)(9) of such Act), the methodology described in section 1881(b) of such Act.

(9) For any other service within a class of services for which the amount of payment made under part B of the medicare program is determined on the basis of reasonable or prevailing charge, the methodology used for payment for such service under such part.

SEC. 6314. SERVICES PROVIDED BY MANAGED CARE ORGANIZATIONS.

(a) **IN GENERAL.**—The maximum payment rates established under this subtitle for capitation payments made to managed care organizations for the guaranteed national benefit package shall be determined using the applicable payment methodologies established under subsection (b).

(b) **PAYMENT METHODOLOGY.**—

(1) **IN GENERAL.**—The Secretary shall establish a system of determining payments to managed care organizations contracting to provide the guaranteed national benefit package on a capitated or risk basis.

(2) **USE OF MEDICARE METHODOLOGY.**—Such methodology shall be based on the methodology used under section 1876 of the Social Security Act, and the payment rates shall reflect the guaranteed national benefit package and a representative population of individuals in the private sector.

(c) **PAYMENT RATES.**—The maximum payment rates under this section shall be equal to 95 percent of the actuarially comparable cost of providing services to individuals not enrolled with managed care organizations, consistent with maximum payment rates established under this part.

SEC. 6315. OTHER SERVICES.

In the case of services within a class of services for which a methodology for establishing maximum payment rates is not otherwise provided pursuant to the preceding provisions of this subtitle, by January 1, 1997, the Secretary shall establish an appropriate methodology for establishing such rates, taking into account the payment methodology or methodologies in use under the medicare program or other health benefit plans, including prospective payment methodologies developed and implemented under section 8002(a).

Subtitle E—Administrative and Judicial Review

SEC. 6401. LIMITATION ON ADMINISTRATIVE AND JUDICIAL REVIEW.

There shall be no administrative or judicial review of any of the following determinations:

(1) the maximum payment rates established under subtitle D, including—

(A) relative values and relative value units and conversion factors;

(B) the establishment of diagnosis-related groups, of the methodology for the classification of discharges within such groups, and of the appropriate weighting factors thereof;

(2) the national private per capita estimate and the State private per capita estimate for each State; and

(3) allocation of the national private per capita estimate or a State private per capita estimate to a class of health services.

Subtitle F—National Health Cost Commission

SEC. 6501. NATIONAL HEALTH COST COMMISSION.

(a) **ESTABLISHMENT.**—By not later than January 1, 1997, the President shall establish a National Health Cost Commission (in this subtitle referred to as the “Commission”).

(b) **COMPOSITION.**—The Commission shall consist of 9 members, appointed by the President, who shall serve at the pleasure of the President. The President shall appoint members based on their expertise and national recognition in the fields of health economics, provider reimbursement, health insurance, health benefits design, and related fields. In appointing members to the Commission, the President shall seek recommendations from the Speaker and majority and minority leaders of the House of Representatives and the majority and minority leaders of the Senate.

(c) **DUTIES.**—

(1) **ANALYSES OF DATA.**—The Commission shall conduct analyses of the health care cost and revenue data reported to the Secretary under section 6004.

(2) **ANNUAL REPORTS.**—Not later than April 1 of each year, beginning in 1998, the Commission shall submit a report to Congress on health care costs in the United States. The report shall include an analysis relating to each of the following:

(A) The rate of growth in health care costs, by type of provider, by type of payer, and by State.

(B) The success or failure of the private sector in maintaining health care expenditures within the national health expenditure estimates established under subtitle A on a State-by-State basis.

(C) The impact of universal coverage on health care costs and on payment for services by private payers.

(D) The future rate of growth in health care costs, based on projections of historical trends, using the same economic assumptions used by the Congressional Budget Office.

(d) **SPECIAL REPORT IN 2000.**—

(1) **IN GENERAL.**—In the report submitted under subsection (c)(2) in 2000, the Commission shall include a specific finding regarding whether a system of cost containment should be imposed on health care services provided under private health benefit plans. The finding shall be based on the most recent data available at the time of the report's preparation.

(2) **RECOMMENDATIONS.**—

(A) **IN GENERAL.**—Such report may recommend that the system of private sector cost containment provided under subtitle C be allowed to go into effect, or may recommend an alternative system.

(B) **LEGISLATIVE PROPOSAL.**—Any recommendations which require legislation to implement shall include a detailed legislative proposal providing for their implementation.

(C) **NO CHANGES IN GUARANTEED NATIONAL BENEFIT PACKAGE.**—Such recommendations shall not include any change in the guaranteed national benefit package.

(e) **ADMINISTRATION.**—The President shall assure such compensation, staff, and support services for the Commission as may be necessary for the Commission to carry out its duties.

SEC. 6502. EXPEDITED CONSIDERATION OF RECOMMENDATIONS AND ALTERNATIVES.

(a) **INTRODUCTION AND REFERRAL.**—

(1) **IN GENERAL.**—If—

(A) the report under section 6501(d) contains a detailed legislative proposal, and

(B) such report is accompanied by a statement (provided by the Director of the Congressional Budget Office under subsection (f)) that the system provided in the proposal meets the cost-containment objectives set forth in this Act,

the majority leader (or the leader's designee) in each House shall introduce (by request and not later than 7 days after the date of receipt by Congress of the report) the legislative proposal as a bill. Such a bill is referred to in this section as a “Commission implementing bill”.

(2) **REFERRAL.**—Commission implementing bills shall be referred on the date of introduction to the appropriate committee (or committees) in accordance with rules of the respective Houses. Such a committee is referred to in this section as an “appropriate committee”.

(b) COMMITTEE CONSIDERATION.—

(1) IN GENERAL.—Each appropriate committee of either House to which a Commission implementing bill has been referred—

(A) shall report the bill with or without recommendation, and

(B) may report as an original bill an alternative implementing bill described in paragraph (2).

(2) ALTERNATIVE IMPLEMENTING BILL.—For purposes of this section, the term “alternative implementing bill” means an original bill, reported by an appropriate committee of a House—

(A) that implements an alternative system of health care cost containment,

(B) that does not include any change in the guaranteed national benefit package,

(C) for which the committee report for the bill is accompanied by a statement (provided by the Director of the Congressional Budget Office under subsection (f)) that the system provided in the bill meets the cost-containment objectives set forth in this Act, and

(D) for which the report is filed before the date the Commission implementing bill is placed on the appropriate calendar of that House under paragraph (4)(A).

(3) DISCHARGE DEADLINE.—If an appropriate committee does not report the Commission implementing bill by the end of the 45-day period beginning on the date the bill was referred to the committee, the committee shall be automatically discharged from further consideration of the bill as of the end of such period.

(4) CALENDARING.—

(A) COMMISSION BILL.—Upon the reporting or discharge of all committees to which the Commission implementing bill is referred in each House, the bill and any alternative implementing bill in that House shall be placed on the appropriate calendar.

(B) ALTERNATIVE BILLS.—Alternative implementing bills, reported by an appropriate committee, shall not be referred to any committee and shall be placed on the appropriate calendar in accordance with subparagraph (A).

(c) FLOOR CONSIDERATION.—

(1) CONSIDERATION OF COMMISSION IMPLEMENTING BILL.—A motion in the House of Representatives or Senate to proceed to the consideration of a Commission implementing bill shall be highly privileged or privileged, respectively, and not debatable.

(2) CONSIDERATION OF ALTERNATIVE IMPLEMENTING BILLS.—

(A) IN GENERAL.—Subject to subparagraph (B), upon rejection of a Commission implementing bill on final passage, a motion in the House of Representatives or Senate to proceed to the consideration of an alternative implementing bill shall be highly privileged or privileged, respectively, and not debatable.

(B) EXCEPTION.—Subparagraph (A) shall not apply after passage of an alternative implementing bill in that House.

(3) GENERAL PROCEDURES APPLICABLE.—

(A) IMPLEMENTING BILL DEFINED.—In this section, the term “implementing bill” means, with respect to a House, the Commission implementing bill and any alternative implementing bill reported by an appropriate committee of that House.

(B) MOTIONS TO PROCEED TO CONSIDERATION.—An amendment to the motion to proceed to the consideration of an implementing bill shall not be in order, nor shall it be in order to move to reconsider the vote by which the motion is agreed to or disagreed to. All points of order against consideration of an implementing bill are hereby waived. Such a motion to proceed shall not be subject to a motion to postpone.

(C) NO AMENDMENTS.—No amendment to an implementing bill is in order.

(D) DEBATE.—

(i) HOUSE OF REPRESENTATIVES.—Debate in the House of Representatives on the Commission implementing bill and on all alternative implementing bills shall be limited to a total of not more than 20 hours to be divided equally between those favoring and those opposing each bill involved. A motion further to limit debate shall not be debatable.

(ii) SENATE.—Debate in the Senate on the Commission implementing bill, on all alternative implementing bills, and on all debatable motions and appeals in connection therewith shall be limited to a total of not

more than 20 hours to be equally divided between and controlled by the majority and minority leaders or their designees. A motion further to limit debate shall not be debatable.

(iii) **SENATE APPEALS.**—Debate in the Senate on any debatable motion or appeal in connection with an implementing bill shall be limited to not more than 1 hour, to be equally divided between, and controlled by, the mover and the manager of the bill, except that in the event the manager of the bill is in favor of any such motion or appeal, the time in opposition thereto shall be controlled by the minority leader or his designee. Such leaders, of either of them, may, from time under their control on the passage of an implementing bill, allot additional time to any Senator during the consideration of any debatable motion or appeal.

(E) **NO RECOMMITTAL.**—It shall not be in order to move to recommit an implementing bill or to move to reconsider the vote by which an implementing bill is agreed to or disagreed to.

(F) **APPEALS.**—All appeals from the decisions of the Chair relating to the application of the Rules of the House of Representatives to the procedure relating to an implementing bill shall be decided without debate.

(G) **FINAL PASSAGE.**—A vote on final passage of an implementing bill shall be taken in a House not later than the end of the 15-day period beginning on the date on which the motion to proceed to its consideration in that House has been approved.

(4) **SPECIAL RULES.**—If the House of Representatives approves an implementing bill and the Senate approves an implementing bill the text of which is identical to the text of the implementing bill approved by the House of Representatives, the Senate is deemed to have approved the implementing bill approved by the House of Representatives, effective on the later of—

(A) the date of approval of an implementing bill in the Senate, or

(B) the date the Senate receives a message from the House of Representatives announcing that the House has passed the implementing bill.

(d) **RULES OF HOUSE OF REPRESENTATIVES AND SENATE.**—This section is enacted by the Congress—

(1) as an exercise of the rulemaking power of the House of Representatives and of the Senate, respectively, and as such they are deemed a part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of implementing bills and they supersede other rules only to the extent that they are inconsistent therewith, and

(2) with full recognition of the constitutional right of either House to change the rules (so far as relating to the procedure of that House) at any time, in the same manner and to the same extent as in the case of any other rule of that House.

(e) **NOT INCLUDING CERTAIN DAYS.**—Days on which a House of Congress is not in session because of an adjournment of more than 3 days shall be excluded in the computation of any number of days in a period under this section with respect to that House.

(f) **CONGRESSIONAL BUDGET OFFICE DETERMINATIONS.**—The Director of the Congressional Budget Office, upon request of the Commission or an appropriate committee, shall—

(1) review any bill to be proposed by the Commission or the committee to determine if the system of health care cost containment reflected in the bill would meet the cost-containment objectives set forth in this Act, and

(2) provide a written statement of such determination.

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Subtitle A—Health Workforce Priorities

PART 1—NATIONAL PLAN REGARDING PHYSICIANS AND OTHER HEALTH PROFESSIONALS

SEC. 7001. NATIONAL PLAN.

(a) **IN GENERAL.**—The Secretary shall develop a plan to be known as the National Health Care Workforce Plan (in this subtitle referred to as the “Plan”).

(b) **PURPOSE.**—The purpose of the Plan shall be to establish a national goal for the United States of developing a health care workforce whose composition reflects the needs of the United States for practitioners in the various health professions, including the need for practitioners in primary care.

(c) **PROVISIONS REGARDING HEALTH PROFESSIONALS OTHER THAN PHYSICIANS.**—With respect to health professionals other than physicians, the Secretary shall in carrying out subsection (b) ensure that the Plan—

(1) establishes recommendations for national goals regarding the number and variety of such professionals that should be trained (including goals regarding nurse practitioners and other advanced practice nurses); and

(2) provides recommendations for encouraging the training of such professionals in accordance with the goals.

(d) **PROVISIONS REGARDING PHYSICIANS.**—

(1) **NATIONWIDE NUMBER OF RESIDENCY POSITIONS PER SPECIALTY; PRIMARY CARE.**—With respect to physicians, the Secretary shall in carrying out subsection (b) ensure that the Plan, for each of the academic years 1998 through 2010, meets the following conditions:

(A) The Plan provides a projection of the number of physicians that will be practicing in the United States in each of the medical specialties.

(B) The Plan specifies, for each medical specialty, the number of individuals nationwide who are authorized for the academic year (pursuant to sections 7011 and 7012) to enter approved medical residency training programs.

(C) The Plan specifies that the nationwide number of residency positions authorized pursuant to subparagraph (B) for a medical specialty for an academic year is to be allocated among approved medical residency training programs in the specialty.

(D) The Plan specifies that, of all residents who enter an initial residency period in an academic year, not less than 55 percent of the residency positions authorized pursuant to subparagraph (B) for the year will be in approved medical residency training programs in primary care. The Secretary may modify the proportion of residents entering primary care under this subparagraph to provide for an appropriate transition to the national goal or to reflect changing needs for physicians in the various medical specialties.

(2) **SPECIAL CONSIDERATION FOR CERTAIN SPECIALTIES OTHER THAN PRIMARY CARE.**—With respect to medical specialties that are not in primary care, the Secretary shall in developing the Plan identify any such specialty for which there is a need to increase the number of physicians being trained, and shall provide special consideration under the Plan for the specialties so identified.

(3) **METHODOLOGY FOR PROGRAM-BY-PROGRAM IMPLEMENTATION OF PLAN.**—In developing the Plan, the Secretary shall develop a methodology for annually allocating among the approved medical residency training programs in a medical specialty the number of residency positions authorized pursuant to paragraph (1)(B) for the specialty for the academic year involved. The Secretary shall include among the factors upon which the methodology is based the following factors:

(A) The geographic distribution of physicians.

- (B) The quality of residency training programs.
- (C) The training of physicians in sites other than hospitals.
- (D) The need to encourage the training of minority physicians.
- (E) The need for appropriate opportunities for training in osteopathic specialties.

(4) **EVALUATION OF PROGRESS.**—The Secretary shall periodically determine the extent to which the authorities provided pursuant to sections 7011 and 7012 have been effective in assuring progress toward achieving the goals established in the Plan with respect to physicians, and shall consider whether there is a need to further such progress through the method of requiring hospitals that operate approved medical residency training programs to enter into an agreement with the Secretary under which compliance with the Plan as applied to the hospitals regarding residency positions is a condition for the receipt under the programs with which such sections are concerned of any payments for the costs of graduate medical education. The Secretary may employ the method to the extent determined by the Secretary to be appropriate.

(e) **PERIODIC REVIEW AND REVISION OF PLAN.**—The Secretary shall periodically review the Plan, and shall revise the Plan to the extent determined by the Secretary to be appropriate (including provisions developed pursuant to subsection (d) with respect to primary care and with respect to methodologies for allocations of residency positions).

(f) **CONSIDERATION OF PROJECTED NUMBERS OF PROFESSIONALS.**—In developing and revising the Plan, the Secretary shall take into account projections of the health care needs of the United States.

(g) **CONSULTATIONS.**—In developing and revising the Plan, the Secretary shall consult with consumers, experts in health workforce needs, teaching physicians, the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, physicians in private practice, nurses, representatives of health insurers (including health maintenance organizations and other managed care plans), other organizations representing physicians, and other organizations involved in the accreditation of residency training programs.

(h) **REPORT TO CONGRESS.**—Not later than December 31, 1995, the Secretary shall submit to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives, and to the Committee on Finance of the Senate, a final report describing the contents of the Plan. The report shall include an analysis of the impact on teaching hospitals and other training programs of limiting support for training, consistent with the Plan. The Secretary may submit interim reports regarding any component of the Plan (regardless of whether the Secretary has prepared other components).

(i) **DEFINITIONS.**—In this title:

(1) The term “academic year” means the 1-year period beginning on July 1. The 1-year period beginning July 1, 1995, is academic year 1995.

(2) The terms “approved medical residency training program” and “resident” have the meaning given such terms in section 1886(h) of the Social Security Act.

(3) The term “primary care” means the specialties of family medicine, general internal medicine, general pediatrics, geriatrics, preventive medicine, obstetrics and gynecology, and osteopathic general practice.

(4) The term “residency position” means a position as a resident in an approved medical residency training program.

SEC. 7002. ALLOCATION OF RESIDENCY POSITIONS AMONG APPROVED MEDICAL RESIDENCY TRAINING PROGRAMS.

(a) **ANNUAL ALLOCATIONS.**—For academic year 1998 and each subsequent academic year, the Secretary shall for each medical specialty make allocations among approved medical residency training programs of the number of residency positions authorized for the specialty for the year pursuant to the Plan under section 7001. Such allocations apply for purposes of section 7011 and the amendments made by section 7012. The Secretary shall notify an approved medical residency training program of the allocation to be made for the program under this section for an academic year not later than 180 days prior to the beginning of the year.

(b) **METHODOLOGY.**—In making allocations under subsection (a), the Secretary shall use the methodology developed under subsection (d)(3) of section 7001 (with such modifications in the methodology as the Secretary may make under subsection (e) of such section).

PART 2—PAYMENTS TO ACADEMIC HEALTH CENTERS

SEC. 7011. PAYMENTS UNDER HEALTH CARE WORKFORCE ACCOUNT REFLECTING PRIVATE-SECTOR SHARE OF GRADUATE MEDICAL EDUCATION; IMPLEMENTATION OF NATIONAL PLAN.

(a) **IN GENERAL.**—From amounts in the Health Care Workforce Account (established under section 9512 of the Internal Revenue Code of 1986), the Secretary shall each calendar year make the following payments to hospitals with approved medical residency training programs:

(1) Payments, made on a periodic basis, whose sum is equal to the amount determined under subsection (c) for the hospital involved for the year (which amount relates to the direct costs for graduate medical education attributable to certain individuals).

(2) Payments, made on a periodic basis, whose sum is equal to the total of the respective per discharge amounts determined under subsection (d) for patient discharges occurring in the year from the hospital involved (which amounts relate to the per discharge indirect costs of the hospital for graduate medical education attributable to certain individuals).

Payments under paragraph (1) are effective for portions of cost reporting periods occurring on or after January 1, 1996. Payments under paragraph (2) are effective for patient discharges occurring on or after such date.

(b) **RELATIONSHIP OF PAYMENTS TO ALLOCATION OF RESIDENCY POSITIONS.**—On and after July 1, 1998, the Secretary, in making determinations under subsections (c) and (d) for the payments required in paragraphs (1) and (2) of subsection (a) for a hospital, shall count only residents who are in a residency position that, under section 7002, has been allocated to an approved medical residency training program of the hospital. In the case of payments under paragraph (1) of subsection (a), the preceding sentence is effective for portions of cost reporting periods occurring on or after such date; and in the case of payments under paragraph (2) of such subsection, the sentence is effective for patient discharges occurring on or after such date.

(c) **AMOUNT OF PAYMENTS; DIRECT COSTS.**—

(1) **IN GENERAL.**—For purposes of paragraph (1) of subsection (a), the amount determined under this subsection for a hospital for a calendar year is the product of—

(A) the aggregate nonmedicare resident amount for the hospital, as defined in paragraph (2); and

(B) the direct-cost Account payout percentage, as defined in paragraph (3).

(2) **AGGREGATE NONMEDICARE RESIDENT AMOUNT.**—For purposes of this subtitle, the term “aggregate nonmedicare resident amount”, with respect to the hospital involved, means an amount equal to the product of—

(A) the number of full-time equivalent residents of the hospital (as determined under section 1886(h)(4) of the Social Security Act) for the cost reporting period involved; and

(B) an amount equal to the product of—

(i) the approved FTE resident amount for the hospital (as determined under section 1886(h)(2) of such Act) for the cost reporting period involved; and

(ii) a percentage equal to 1 minus the sum of—

(I) the medicare patient load of the hospital (determined under section 1886(h)(3)(C) of the Social Security Act) for the cost reporting period involved, except that the determination of the medicare patient load for purposes of this subclause shall include (in addition to the patients included under such section) patients enrolled in the program under part A of title XXIII of such Act; and

(II) the medicaid patient load of the hospital, which term shall, in the case of the hospital involved, be defined by the Secretary with respect to the program under title XIX of the Social Security Act in a manner equivalent to the manner in which the term “medicare patient load” is defined with respect to the program under title XVIII of such Act.

(3) **DIRECT-COST ACCOUNT PAYOUT PERCENTAGE.**—For purposes of this subtitle, the term “direct-cost Account payout percentage”, with respect the calendar year involved, means a percentage equal to the ratio of—

(A) the amount available in the Health Care Workforce Account for such year (as estimated by the Secretary); to

(B) an amount equal to the sum of clauses (i) and (ii), as follows:

(i) The total amount of payments under subsection (a)(1) that would be made to hospitals for such year if each hospital received, pursuant to paragraph (1), 100 percent of the aggregate nonmedicare resident amount determined for the hospital.

(ii) The total of the amounts determined under subsection (d)(2)(A) of section 7013 for the calendar year for hospitals eligible for payments under such section.

(d) AMOUNT OF PAYMENTS; INDIRECT COSTS.—

(1) IN GENERAL.—For purposes of paragraph (2) of subsection (a), the per discharge payment determined under this subsection for a hospital for a discharge is the product of—

(A) an amount equal to the maximum payment rate applicable to the discharge under section 6311 multiplied by the percentage applicable to the hospital under section 1886(d)(5)(B)(ii) of the Social Security Act; and

(B) the indirect-cost Account payout percentage, as defined in paragraph (2).

(2) INDIRECT-COST ACCOUNT PAYOUT PERCENTAGE.—For purposes of this subtitle, the term “indirect-cost Account payout percentage”, with respect the calendar year involved, means a percentage equal to the ratio of—

(A) the amount available in the Health Care Workforce Account for such year remaining after payments under subsection (a)(1) have been made for the year (as such amount is estimated by the Secretary); to

(B) an amount equal to the total of the respective amounts determined under paragraph (1)(A) for all discharges for such year, other than discharges of patients who are entitled to benefits under part A of title XVIII of the Social Security Act, are enrolled in the health insurance program under part A of title XXIII of such Act, or are eligible for medical assistance under title XIX of such Act.

(e) OFFSET REGARDING SHORTFALL IN ACCOUNT PAYMENTS; INCREASE IN MAXIMUM PAYMENT RATES UNDER TITLE VI.—

(1) SHORTFALL IN DIRECT-COST PAYMENTS.—

(A) IN GENERAL.—For any calendar year for which the direct-cost Account payout percentage is less than 100 percent, the Secretary shall increase, by the amount determined under subparagraph (B), the maximum payment rate otherwise applicable to a discharge from a hospital under subtitle D of title VI for inpatient services furnished by the hospital. The amount so determined shall be applied uniformly to each discharge from the hospital. This subsection is subject to paragraph (3).

(B) AMOUNT OF INCREASE.—For purposes of subparagraph (A), the amount of the increase per discharge for a calendar year for a hospital is the product of—

(i) a percentage equal to 1 minus the direct-cost Account payout percentage; and

(ii) the applicable per discharge resident amount for the hospital, as defined in subparagraph (C).

(C) APPLICABLE PER DISCHARGE RESIDENT AMOUNT.—For purposes of this subtitle, the term “applicable per discharge resident amount”, with respect to the hospital involved and the calendar year involved, means an amount equal to the quotient of—

(i) the aggregate nonmedicare resident amount for the hospital, as determined under subsection (c)(1)(A); divided by

(ii) the average annual number of inpatient discharges during the most recent 3-year period (as determined by the Secretary on the basis of the most recent data available to the Secretary).

(2) SHORTFALL IN INDIRECT-COST PAYMENTS.—

(A) IN GENERAL.—For any calendar year for which the indirect-cost Account payout percentage is less than 100 percent, the Secretary shall increase, by the amount determined under subparagraph (B), the maximum payment rate per discharge otherwise established under section 6311 with respect to the discharge. The preceding sentence is subject to paragraph (3).

(B) AMOUNT OF INCREASE.—For purposes of subparagraph (A), the amount of the per discharge increase for a hospital for a calendar year is the product of—

(i) a percentage equal to 1 minus the indirect-cost Account payout percentage; and

(ii) an amount equal to the maximum payment rate applicable to the discharge under section 6311 multiplied by the percentage applicable to the hospital under section 1886(d)(5)(B)(ii) of the Social Security Act.

(3) **RELATIONSHIP OF RATE INCREASES TO ALLOCATIONS OF RESIDENCY POSITIONS.**—Effective for patient discharges occurring on or after July 1, 1998, the Secretary, in making determinations under paragraphs (1) and (2) of increases in amounts, shall count only residents who are in a residency position that, under section 7002, has been allocated to an approved medical residency training program.

(f) **PUBLICATION OF ACCOUNT PAYOUT PERCENTAGES AND ADJUSTMENTS IN MAXIMUM PAYMENT RATES.**—The Secretary shall include in the publication of the final maximum payment rates for a calendar year under section 6301(a)—

- (1) the direct-cost Account payout percentage;
- (2) the indirect-cost Account payout percentage; and
- (3) the hospital-specific adjustments in such rates determined under paragraph (1) or (2) of subsection (e).

(g) **CONDITIONS FOR RECEIVING PAYMENTS AND RATE INCREASES.**—The requirement to make payments under subsection (a) to a hospital, or to increase maximum payment rates under subsection (e), applies only if the hospital involved submits to the Secretary, in accordance with such requirements as the Secretary may establish, information determined by the Secretary to be necessary to carry out this section.

SEC. 7012. PAYMENTS UNDER MEDICARE; IMPLEMENTATION OF NATIONAL PLAN.

(a) **PAYMENT FOR DIRECT MEDICAL EDUCATION.**—Section 1886(h)(4) of the Social Security Act (42 U.S.C. 1395ww(h)(4)) is amended by adding at the end the following new subparagraph:

“(F) **REQUIRING RESIDENTS TO MEET APPROVAL UNDER WORKFORCE PROGRAM.**—Such rules shall provide that, with respect to residents who begin an initial residency period on or after July 1, 1998, an individual shall be counted only if the individual is in a residency position that, under section 7002 of the Health Security Act, has been allocated to an approved medical residency training program.”.

(b) **PAYMENT FOR INDIRECT MEDICAL EDUCATION.**—Section 1886(d)(5)(B) of such Act (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding at the end the following new clause:

“(v) On and after July 1, 1998, the Secretary, in determining such adjustment, may count a resident in the calculation of a hospital’s ratio of full-time equivalent interns and residents to beds only if the resident is in a residency position that, under section 7002 of the Health Security Act, has been allocated to an approved medical residency training program.”.

SEC. 7013. TRANSITIONAL PAYMENTS FOR HOSPITALS LOSING RESIDENCY POSITIONS.

(a) **PAYMENTS REGARDING EFFECTS OF ALLOCATION OF RESIDENCY POSITIONS.**—In the case of a hospital that for academic year 1998 or any subsequent academic year submits to the Secretary an application for the year in accordance with subsection (c), the Secretary shall make payments for the year to the hospital for the purpose specified in subsection (b)(2). The Secretary shall make the payments in an amount determined in accordance with subsection (d), and may administer the payments as a contract, grant, or cooperative agreement.

(b) **HOSPITALS LOSING RESIDENCY POSITIONS; OTHER CONDITIONS.**—

(1) **HOSPITALS LOSING RESIDENCY POSITIONS.**—

(A) **IN GENERAL.**—The Secretary may make payments under subsection (a) to a hospital for an academic year only if, as a result of allocations under 7002, the aggregate number of full-time equivalent residency positions for the hospital for the year (as estimated by the Secretary) is below the aggregate number of such positions for the hospital for academic year 1993.

(B) **AGGREGATE NUMBER OF RESIDENCY POSITIONS LOST.**—For purposes of this section, the term “aggregate number of residency positions lost”, with respect to a hospital and an academic year, means the difference between the 2 aggregate numbers determined by the Secretary under paragraph (1) for the hospital.

(2) **PURPOSE OF PAYMENTS.**—The purpose of payments under subsection (a) is to assist an eligible hospital with the costs of operation. The Secretary may make such payments for an academic year only if the hospital involved agrees to expend the payments for such purpose.

(3) **COMPLIANCE WITH ALLOCATION SYSTEM.**—The Secretary may make payments under subsection (a) to a hospital for an academic year only if the hospital agrees that the number of residents in each of the approved medical residency training programs of the hospital will be in accordance with the allocations made under section 7002 for the programs for the year.

(4) **ELIGIBLE HOSPITAL.**—For purposes of this section, the term “eligible hospital” means a hospital that submits to the Secretary an application in accordance with subsection (c).

(c) **APPLICATION FOR PAYMENTS.**—For purposes of subsection (a), an application for payments under such subsection is in accordance with this subsection if—

(1) the hospital submits the application not later than the date specified by the Secretary;

(2) the application demonstrates that the hospital meets the condition described in subsection (b)(1)(A);

(3) the application contains each agreement required in this section, and such assurances of compliance with the agreements as the Secretary may require; and

(4) the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary.

(d) **AMOUNT OF PAYMENTS.**—

(1) **IN GENERAL.**—The amount of payments required in subsection (a) to be made to an eligible hospital for an academic year is the sum of—

(A) the amount determined under paragraph (2), which amount shall be paid from amounts available in the Health Care Workforce Account (established under section 9512 of the Internal Revenue Code); and

(B) the amount determined under paragraph (3), which shall be paid from the Hospital Insurance Trust Fund and the Supplementary Medical Insurance Trust Fund under title XVIII of the Social Security Act, and the Medicare Part C Trust Fund under title XXIII of such Act (in the proportions described in section 1886(h)(1) of such Act, taking into account the proportions of direct medical education costs associated with the provision of services under such title XXIII).

(2) **AMOUNT RELATING TO HEALTH CARE WORKFORCE ACCOUNT.**—For purposes of paragraph (1)(A), the amount determined under this paragraph for an eligible hospital for an academic year is an amount equal to the product of—

(A) an amount equal to the product of—

(i) the aggregate lost position amount, as defined in subsection (e) for the academic year; and

(ii) 1 minus the medicare patient load determined under paragraph (3)(B); and

(B) the direct-cost Account payout percentage under section 7011(c)(3).

(3) **AMOUNT RELATING TO MEDICARE TRUST FUNDS.**—For purposes of paragraph (1)(B), the amount determined under this paragraph for an eligible hospital for an academic year is an amount equal to the product of—

(A) the aggregate lost position amount, as defined in subsection (e) for the academic year; and

(B) the medicare patient load of the hospital (determined under section 1886(h)(3)(C) of the Social Security Act) for the cost reporting period involved, except that the determination of the medicare patient load for purposes of this subparagraph shall include (in addition to the patients included under such section) patients enrolled in the program under part A of title XXIII of such Act.

(e) **AGGREGATE LOST POSITION AMOUNT.**—

(1) **FIRST ACADEMIC YEAR OF RECEIVING PAYMENTS.**—For purposes of paragraphs (2) and (3) of subsection (d), the term “aggregate lost position amount”, with respect to the first academic year for which an eligible hospital receives payments under subsection (a), means an amount equal to the product of—

(A) the aggregate number of residency positions lost (as defined in subsection (b)(1)(B)); and

(B) an amount equal to 100 percent of the approved FTE resident amount for the hospital (determined under section 1886(h)(2) of the Social Security Act) for the portions of cost reporting periods occurring during the academic year.

(2) **OTHER ACADEMIC YEARS.**—For purposes of paragraphs (2) and (3) of subsection (d), the term “aggregate lost position amount”, with respect to the second or subsequent academic year for which an eligible hospital receives payments under subsection (a), means an amount equal to the sum of subparagraphs (A) through (D), as follows:

(A) An amount equal to the product of—

(i) the aggregate number of residency positions lost, less an amount equal to the sum of—

(I) the number of lost positions for which payments are being made for the academic year pursuant to subparagraphs (B) through (D); and

(II) the total number of lost positions for which, in determinations under this subsection for the hospital for prior academic years, the percentage applicable to the approved FTE resident amount for the hospital was 25 percent; and

(ii) 100 percent of the approved FTE resident amount for the hospital for portions of cost reporting period occurring during the academic year involved.

(B) An amount equal to the product of—

(i) the number of lost positions for which, in the determination under this subsection for the preceding academic year, the percentage applicable to the approved FTE resident amount for the hospital was 100 percent, subject to paragraph (3) (relating to decreases in aggregate numbers); and

(ii) 75 percent of the approved FTE resident amount for the hospital for portions of cost reporting period occurring during the academic year involved.

(C) An amount equal to the product of—

(i) the number of lost positions for which, in the determination under this subsection for the preceding academic year, the percentage applicable to the approved FTE resident amount for the hospital was 75 percent, subject to paragraph (3); and

(ii) 50 percent of the approved FTE resident amount for the hospital for portions of cost reporting period occurring during the academic year involved.

(D) An amount equal to the product of—

(i) the number of lost positions for which, in the determination under this subsection for the preceding academic year, the percentage applicable to the approved FTE resident amount for the hospital was 50 percent, subject to paragraph (3); and

(ii) 25 percent of the approved FTE resident amount for the hospital for portions of cost reporting period occurring during the academic year involved.

(3) RULE REGARDING DECREASE IN AGGREGATE NUMBER OF LOST POSITIONS.—With respect to payments under subsection (a) for an eligible hospital for an academic year, if the aggregate number of residency positions lost for the year is less than such number for the preceding academic year (which difference between the 2 aggregate numbers is referred to in this paragraph as the “decrease in the number of lost positions”), the following applies:

(A) The Secretary shall identify the number of lost positions for which, as determined under paragraph (2) without regard to this paragraph, the percentage applicable to the approved FTE resident amount for the hospital is 100 percent, the number of such positions for which such percentage is 75 percent, the number of such positions for which such percentage is 50 percent, and the number of such positions for which such percentage is 25 percent.

(B) In the case of the lost positions so identified, the Secretary shall apply the decrease in the number of lost positions as follows:

(i) First, as a reduction in the number of positions for which the percentage applicable is 100 percent.

(ii) Second (for any remaining portions of the decrease after compliance with clause (i)), as a reduction in the number of positions for which such percentage is 75 percent.

(iii) Third (for any remaining portions of the decrease after compliance with clause (ii)), as a reduction in the number of positions for which such percentage is 50 percent.

(iv) Fourth (for any remaining portions of the decrease after compliance with clause (iii)), as a reduction in the number of positions for which such percentage is 25 percent.

(4) DEFINITION.—For purposes of this subsection, the term “lost position”, with respect to an academic year, means a full-time equivalent residency position counted in the determination under subsection (b) of the aggregate number of residency positions lost for the year.

(f) RULE REGARDING CERTAIN NUMBERS.—In determinations under this section, a negative number shall be deemed to be a zero.

PART 3—OTHER PROVISIONS REGARDING GRADUATE MEDICAL EDUCATION

SEC. 7021. DETERMINATION UNDER MEDICARE OF NUMBER OF FULL-TIME EQUIVALENT RESIDENTS.

(a) DETERMINATION OF FULL-TIME-EQUIVALENT RESIDENTS DURING INITIAL RESIDENCY PERIOD.—

(1) EMPHASIS ON PRIMARY CARE.—Paragraph (4)(C)(ii) of section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) is amended by striking “is 1.00,” and inserting the following: “is—

“(I) 1.1, in the case of a resident who is a primary care resident (as defined in paragraph (5)(H)),

“(II) .8, in the case of a resident not described in subclause (I).”

(2) TREATING OBSTETRICS AND GYNECOLOGY RESIDENTS AS PRIMARY CARE RESIDENTS.—Paragraph (5) of such section is amended—

(A) by striking “or”; and

(B) by striking the period and inserting “, or obstetrics and gynecology.”

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to portions of cost reporting periods beginning on or after January 1, 1996.

SEC. 7022. INCREASE IN PAYMENTS FOR FEDERALLY QUALIFIED HEALTH CENTERS.

(a) IN GENERAL.—Section 1833(a)(3) of the Social Security Act (42 U.S.C. 1395l(a)(3)) is amended by inserting after “1861(v)(1)(A),” the following: “and, in the case of services described in subparagraph (D)(ii) of such section, which include any costs associated with participation in an approved medical residency training program (as defined in section 1886(h)(5)(A)) as determined based on the portion of time spent by a resident or intern at the center and adjusted by a factor reflecting the relative indirect and direct costs of such participation.”

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to costs incurred on or after January 1, 1996.

SEC. 7023. MEDICARE DEMONSTRATION REGARDING CONSORTIA OF HOSPITALS.

(a) IN GENERAL.—The Secretary shall establish and conduct not more than 10 demonstration projects to increase the number and percentage of medical students entering primary care practice relative to those entering nonprimary care practice under which the Secretary shall make payments in accordance with subsection (c) to participating health care training consortia.

(b) APPLICATIONS.—Each consortium desiring to participate in a demonstration project under this section shall prepare and submit to the Secretary an application at such time and in such manner as the Secretary may require, and containing—

(1) assurances that not less than 55 percent of all residents participating in approved residency training programs conducted by members of the consortium are primary care residents (as defined in section 1886(h)(5)(H) of the Social Security Act); and

(2) such other information and assurances as the Secretary may require.

(c) PAYMENTS TO PARTICIPANTS.—

(1) IN GENERAL.—Notwithstanding any provision of title XVIII of the Social Security Act—

(A) in the case of a consortium participating in a demonstration project under this subtitle, the Secretary shall make payments under such title for the direct and indirect costs of graduate medical education of members of the consortium to the consortium (or through any entity identified by such a consortium as appropriate for receiving payments on behalf of the consortium), except that the amount paid to the consortium shall be based on the designations described in paragraph (2); and

(B) the Secretary may not make any payment under such title to a member of a consortium for the direct and indirect costs of graduate medical education during the period of the consortium's participation in the demonstration project.

(2) DESIGNATION OF RESIDENTS BY CONSORTIUM.—Each consortium participating in a demonstration project shall designate for each resident assigned to the consortium a hospital operating an approved medical residency training program for purposes of enabling the Secretary to calculate the amount paid to the consortium under paragraph (1)(A). Such hospital shall be the hospital where the resident receives the majority of the resident's hospital-based, non-ambulatory training experience.

(3) LIMIT ON PAYMENT.—The amount paid to a consortium under paragraph (1)(A) during a year may not exceed the Secretary's estimate of the sum of the

payments that would have been made under title XVIII to each member of the consortium during the year but for the application of this section, determined as if such payments were based on—

(A) the number of full-time-equivalent residents in approved medical residency training programs of the member calculated under section 1886(h)(4) of the Social Security Act during the academic year beginning July 1, 1993; and

(B) the ratio of the member's full-time equivalent interns and residents to beds applicable under section 1886(d)(5)(B)(ii) of such Act for discharges occurring during the 12-month cost reporting period beginning or after July 1, 1993.

(d) DURATION.—A demonstration project under this section shall be conducted for a period not to exceed 10 years. The Secretary may terminate a project if the Secretary determines that the consortium participating in the project is not in substantial compliance with the terms of the application approved by the Secretary.

(e) EVALUATIONS AND REPORTS.—

(1) EVALUATIONS.—Each consortium participating in a demonstration project shall submit to the Secretary a final evaluation within 360 days of the termination of the consortium's participation and such interim evaluations as the Secretary may require.

(2) REPORTS TO CONGRESS.—Not later than 360 days after the first demonstration project under this section begins, and annually thereafter for each year in which such a project is conducted, the Secretary shall submit a report to Congress which evaluates the effectiveness of the consortium activities conducted under such projects and includes any legislative recommendations determined appropriate by the Secretary.

(f) DEFINITIONS.—In this section:

(1) APPROVED MEDICAL RESIDENCY TRAINING PROGRAM.—The term "approved medical residency training program" has the meaning given such term in section 1886(h)(5)(A) of the Social Security Act.

(2) HEALTH CARE TRAINING CONSORTIUM.—The term "health care training consortium" means a State, regional, or local entity consisting of at least 2 hospitals operating approved medical residency training programs.

(3) RESIDENT.—The term "resident" has the meaning given such term in section 1886(h)(5)(H) of the Social Security Act.

SEC. 7024. STUDY OF PAYMENTS FOR MEDICAL EDUCATION AT SITES OTHER THAN HOSPITALS.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study of the feasibility and desirability of making payments to facilities that are not hospitals for the direct and indirect costs of graduate medical education attributable to residents trained at such facilities. In conducting the study, the Secretary shall evaluate new payment methodologies—

(1) under which each entity which incurs costs of graduate medical education shall receive reimbursement for such costs; and

(2) which would encourage the training of primary care physicians.

(b) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit a report to Congress a report on the study conducted under subsection (a), and shall include in the report such recommendations as the Secretary considers appropriate.

Subtitle B—Additional Provisions Regarding Primary Care

SEC. 7101. CHANGES IN UNDERSERVED AREA BONUS PAYMENTS.

(a) INCREASE IN AMOUNT OF PAYMENT FOR PRIMARY CARE SERVICES.—Section 1833(m) of the Social Security Act (42 U.S.C. 1395l(m)) is amended by inserting after "10 percent" the following: "(or, in the case of primary care services defined in section 1842(i)(4), 20 percent)".

(b) EXTENSION TO SERVICES FURNISHED IN AREAS LOSING DESIGNATION.—Section 1833(m) of such Act (42 U.S.C. 1395l(m)) is amended by striking "area," and inserting "area (or was designated as such an area at any time during the 36-month period ending on the date the services are furnished)".

(c) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to services furnished on or after January 1, 1998.

SEC. 7102. PAYMENTS FOR MEDICAL SCHOOLS.

(a) **IN GENERAL.**—In the case of a medical school described in subsection (c) that in accordance with subsection (d) submits to the Secretary an application for calendar year 1996 or any subsequent calendar year, the Secretary shall make payments for such year to the school for the purpose specified in subsection (b). Such payments shall be made from the Undergraduate Medical Education Program Account (established under section 9512 of the Internal Revenue Code of 1986). The Secretary shall make the payments in an amount determined in accordance with subsection (e), and may administer the payments as a contract, grant, or cooperative agreement.

(b) **PAYMENTS FOR OPERATION OF SCHOOLS.**—The purpose of payments under subsection (a) is to assist medical schools with the costs of operating the schools.

(c) **CERTAIN REQUIREMENTS.**—For purposes of subsection (a), a medical school described in this subsection is a medical school that meets the following conditions:

(1) The school maintains a program to recruit individuals who are members of racial or ethnic minority groups that are underrepresented in medical schools.

(2) The school maintains a program to encourage students of the school to enter a field in primary care.

(3) The programs referred to in paragraphs (1) and (2) meet such criteria as the Secretary may establish.

(d) **APPLICATION FOR PAYMENTS.**—For purposes of subsection (a), an application for payments under such subsection for a calendar year is in accordance with this subsection if—

(1) the application is submitted not later than the date specified by the Secretary;

(2) the application demonstrates that the medical school involved meets the conditions described in subsection (c); and

(3) the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

(e) **AMOUNT OF PAYMENTS.**—The amount of payments required in subsection (a) for a medical school for a calendar year is an amount determined in accordance with a formula established by the Secretary on the basis of the amount in the Undergraduate Medical Education Program Account for the year (as estimated by the Secretary) and on the basis of the following factors:

(1) The proportion of the student enrollment of the school constituted by individuals described in subsection (c)(1).

(2) The proportion of the graduates of the school who enter a field in primary care.

(3) The extent to which the educational policies of the school foster the goals of the Plan under section 7001.

(f) **DEFINITIONS.**—For purposes of this section:

(1) The term “medical school” means a school of medicine or osteopathic medicine, as defined in section 799 of the Public Health Service Act.

(2) The term “primary care” has the meaning given such term in section 7001(i).

SEC. 7103. STUDY OF FUNDING NEEDS OF HEALTH PROFESSIONS SCHOOLS.

(a) **IN GENERAL.**—The Secretary shall conduct a study for the purpose of determining the funding needs of health professions schools, including schools of medicine and osteopathic medicine, schools of dentistry, and schools of public health.

(b) **CONSIDERATION OF CERTAIN COSTS.**—In conducting out the study under subsection (a), the Secretary shall also consider the following costs regarding the funding needs of health professions schools:

(1) Uncompensated costs incurred in providing health care.

(2) Costs resulting from reduced productivity due to teaching responsibilities.

(3) Increased costs of caring for the health needs of patients with severe medical complications.

(4) Uncompensated costs incurred by faculty, residents, and students in providing consultations for hospitalized patients.

(5) Uncompensated costs incurred in conducting clinical research.

(c) **CONSIDERATIONS REGARDING ADDITIONAL FUNDING.**—In conducting the study under subsection (a), the Secretary shall determine the following:

(1) Whether the health professions schools involved have a significant need for an increase in the amount of funds available to the schools.

(2) If there is such a need—

(A) recommendations regarding the sources of funds to provide the increase; and

(B) recommendations for a methodology for determining the amount that should be provided to the schools involved.

(d) REPORT TO CONGRESS.—Not later than 18 months after the date of the enactment of this Act, the Secretary shall submit to the Congress a report describing the findings and recommendations made in the study.

Subtitle C—Essential Health Facilities

SEC. 7201. ESSENTIAL ACCESS COMMUNITY HOSPITALS.

(a) INCREASING NUMBER OF PARTICIPATING STATES.—Section 1820(a)(1) of the Social Security Act (42 U.S.C. 1395i-4(a)(1)) is amended by striking “not more than 7”.

(b) TREATMENT OF INPATIENT HOSPITAL SERVICES PROVIDED IN RURAL PRIMARY CARE HOSPITALS.—

(1) IN GENERAL.—Section 1820(f)(1)(F) of such Act (42 U.S.C. 1395i-4(f)(1)(F)) is amended to read as follows:

“(F) subject to paragraph (4), provides not more than 6 inpatient beds (meeting such conditions as the Secretary may establish) for providing inpatient care to patients requiring stabilization before discharge or transfer to a hospital, except that the facility may not provide any inpatient hospital services—

“(i) to any patient whose attending physician does not certify that the patient may reasonably be expected to be discharged or transferred to a hospital within 72 hours of admission to the facility; or

“(ii) consisting of surgery or any other service requiring the use of general anesthesia (other than surgical procedures specified by the Secretary under section 1833(i)(1)(A)), unless the attending physician certifies that the risk associated with transferring the patient to a hospital for such services outweighs the benefits of transferring the patient to a hospital for such services.”.

(2) LIMITATION ON AVERAGE LENGTH OF STAY.—Section 1820(f) of such Act (42 U.S.C. 1395i-4(f)) is amended by adding at the end the following new paragraph:

“(4) LIMITATION ON AVERAGE LENGTH OF INPATIENT STAYS.—The Secretary may terminate a designation of a rural primary care hospital under paragraph (1) if the Secretary finds that the average length of stay for inpatients at the facility during the previous year in which the designation was in effect exceeded 72 hours. In determining the compliance of a facility with the requirement of the previous sentence, there shall not be taken into account periods of stay of inpatients in excess of 72 hours to the extent such periods exceed 72 hours because transfer to a hospital is precluded because of inclement weather or other emergency conditions.”.

(3) CONFORMING AMENDMENT.—Section 1814(a)(8) of such Act (42 U.S.C. 1395f(a)(8)) is amended by striking “such services” and all that follows and inserting “the individual may reasonably be expected to be discharged or transferred to a hospital within 72 hours after admission to the rural primary care hospital.”.

(4) GAO REPORTS.—Not later than 2 years after the date of the enactment of this Act, the Comptroller General shall submit reports to Congress on—

(A) the application of the requirements under section 1820(f) of the Social Security Act (as amended by this subsection) that rural primary care hospitals provide inpatient care only to those individuals whose attending physicians certify may reasonably be expected to be discharged within 72 hours after admission and maintain an average length of inpatient stay during a year that does not exceed 72 hours; and

(B) the extent to which such requirements have resulted in such hospitals providing inpatient care beyond their capabilities or have limited the ability of such hospitals to provide needed services.

(c) DESIGNATION OF HOSPITALS.—

(1) PERMITTING DESIGNATION OF HOSPITALS LOCATED IN URBAN AREAS.—

(A) IN GENERAL.—Section 1820 of such Act (42 U.S.C. 1395i-4) is amended—

(i) by amending paragraph (1) of subsection (e) to read as follows:

“(1) is participating in a rural health network that includes at least one rural primary care hospital designated by the State under subsection (f);”;

(ii) in subsection (e)(2)(A)—

(I) by striking “is located” and inserting “except in the case of a hospital located in an urban area, is located”;

(II) by striking “, (ii)” and inserting “or (ii)”, and

(III) by striking “or (iii)” and all that follows through “section,”; and

(iii) in subsection (i)(1)(B), by striking “paragraph (3)” and inserting “paragraph (2)”.

(B) NO CHANGE IN MEDICARE PROSPECTIVE PAYMENT.—Section 1886(d)(5)(D) of such Act (42 U.S.C. 1395ww(d)(5)(D)) is amended—

(i) in clause (iii)(III), by inserting “located in a rural area and” after “that is”, and

(ii) in clause (v), by inserting “located in a rural area and” after “in the case of a hospital”.

(2) PERMITTING HOSPITALS LOCATED IN ADJOINING STATES TO PARTICIPATE IN STATE PROGRAMS.—

(A) IN GENERAL.—Section 1820 of such Act (42 U.S.C. 1395i-4) is amended—

(i) by redesignating subsection (k) as subsection (l); and

(ii) by inserting after subsection (j) the following new subsection:

“(k) ELIGIBILITY OF HOSPITALS NOT LOCATED IN PARTICIPATING STATES.—Notwithstanding any other provision of this section—

“(1) for purposes of including a hospital or facility as a member institution of a rural health network, a State may designate a hospital or facility that is not located in the State as an essential access community hospital or a rural primary care hospital if the hospital or facility is located in an adjoining State and is otherwise eligible for designation as such a hospital;

“(2) the Secretary may designate a hospital or facility that is not located in a State receiving a grant under subsection (a)(1) as an essential access community hospital or a rural primary care hospital if the hospital or facility is a member institution of a rural health network of a State receiving a grant under such subsection; and

“(3) a hospital or facility designated pursuant to this subsection shall be eligible to receive a grant under subsection (a)(2).”.

(B) CONFORMING AMENDMENTS.—(i) Section 1820(c)(1) of such Act (42 U.S.C. 1395i-4(c)(1)) is amended by striking “paragraph (3)” and inserting “paragraph (3) or subsection (k)”.

(ii) Paragraphs (1)(A) and (2)(A) of section 1820(i) of such Act (42 U.S.C. 1395i-4(i)) are each amended—

(I) in clause (i), by striking “(a)(1)” and inserting “(a)(1) (except as provided in subsection (k))”, and

(II) in clause (ii), by striking “subparagraph (B)” and inserting “subparagraph (B) or subsection (k)”.

(d) SKILLED NURSING SERVICES IN RURAL PRIMARY CARE HOSPITALS.—Section 1820(f)(3) of such Act (42 U.S.C. 1395i-4(f)(3)) is amended by striking “because the facility” and all that follows and inserting the following: “because, at the time the facility applies to the State for designation as a rural primary care hospital, there is in effect an agreement between the facility and the Secretary under section 1883 under which the facility’s inpatient hospital facilities are used for the furnishing of extended care services, except that the number of beds used for the furnishing of such services may not exceed the total number of licensed inpatient beds at the time the facility applies to the State for such designation (minus the number of inpatient beds used for providing inpatient care pursuant to paragraph (1)(F)). For purposes of the previous sentence, the number of beds of the facility used for the furnishing of extended care services shall not include any beds of a unit of the facility that is licensed as a distinct-part skilled nursing facility at the time the facility applies to the State for designation as a rural primary care hospital.”.

(e) DEADLINE FOR DEVELOPMENT OF PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—Section 1814(l)(2) of such Act (42 U.S.C. 1395fl(2)) is amended by striking “January 1, 1993” and inserting “January 1, 1996”.

(f) PAYMENT FOR OUTPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—

(1) IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.—Section 1834(g) of such Act (42 U.S.C. 1395m(g)) is amended—

(A) in paragraph (1), by striking “during a year before 1993” and inserting “during a year before the prospective payment system described in paragraph (2) is in effect”; and

(B) in paragraph (2), by striking “January 1, 1993,” and inserting “January 1, 1996,”.

(2) NO USE OF CUSTOMARY CHARGE IN DETERMINING PAYMENT.—Section 1834(g)(1) of such Act (42 U.S.C. 1395m(g)(1)) is amended by adding at the end the following new flush sentence:

“The amount of payment shall be determined under either method without regard to the amount of the customary or other charge.”.

(g) REQUIREMENTS RELATING TO RURAL HEALTH CARE PLAN.—

(1) IN GENERAL.—Section 1820(b)(1)(A) of such Act (42 U.S.C. 1395i-4(b)(1)(A)) is amended—

(A) by striking “and” at the end of clause (iii);

(B) by striking the semicolon at the end of clause (iv) and inserting “, and”; and

(C) by adding at the end the following new clause:

“(v) meets such other requirements as the Secretary may establish regarding the quality and effectiveness of such plans;”.

(2) TECHNICAL ASSISTANCE.—At the request of a State submitting an application for a grant under section 1820 of the Social Security Act, the Secretary of Health and Human Services shall provide technical assistance to the State for the development of the State’s rural health care plan described in section 1820(b)(1) of such Act.

(h) SERVICE AREA OF FACILITIES INCLUDED IN RURAL HEALTH NETWORKS.—Section 1820(g) of such Act (42 U.S.C. 1395i-4(g)) is amended—

(1) by striking “and” at the end of paragraph (1);

(2) by striking the period at the end of paragraph (2) and inserting “, and”; and

(3) by adding at the end the following new paragraph:

“(3) the members of which provide services in the same general geographic area (in accordance with criteria established by the Secretary).”.

(i) PAYMENT FOR SERVICES OF ESSENTIAL ACCESS COMMUNITY HOSPITALS.—

(1) REPEAL OF CATEGORICAL TREATMENT AS SOLE COMMUNITY HOSPITAL.—Section 1886(d)(5)(D)(iii) of such Act (42 U.S.C. 1395ww(d)(5)(D)(iii)) is amended—

(A) by adding “or” at the end of subclause (I);

(B) by striking “or” at the end of subclause (II); and

(C) by striking subclause (III).

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to discharges occurring on or after October 1, 1996.

(3) REPORT ON APPROPRIATE PAYMENT METHODOLOGY.—Not later than September 1, 1995, the Prospective Payment Assessment Commission shall submit a report to Congress recommending appropriate adjustments in the methodology used to determine the amounts paid to essential access community hospitals for the operating costs of inpatient hospital services under part A of the medicare program to take into account the special needs of such hospitals.

(j) CLARIFICATION OF PHYSICIAN STAFFING REQUIREMENT FOR RURAL PRIMARY CARE HOSPITALS.—Section 1820(f)(1)(H) of such Act (42 U.S.C. 1395i-4(f)(1)(H)) is amended by striking the period and inserting the following: “, except that in determining whether a facility meets the requirements of this subparagraph, subparagraphs (E) and (F) of that paragraph shall be applied as if any reference to a ‘physician’ is a reference to a physician as defined in section 1861(r)(1).”.

(k) TECHNICAL AMENDMENTS RELATING TO PART A DEDUCTIBLE, COINSURANCE, AND SPELL OF ILLNESS.—(1) Section 1812(a)(1) of such Act (42 U.S.C. 1395d(a)(1)) is amended—

(A) by striking “inpatient hospital services” the first place it appears and inserting “inpatient hospital services or inpatient rural primary care hospital services”;

(B) by striking “inpatient hospital services” the second place it appears and inserting “such services”; and

(C) by striking “and inpatient rural primary care hospital services”.

(2) Sections 1813(a) and 1813(b)(3)(A) of such Act (42 U.S.C. 1395e(a), 1395e(b)(3)(A)) are each amended by striking “inpatient hospital services” each place it appears and inserting “inpatient hospital services or inpatient rural primary care hospital services”.

(3) Section 1813(b)(3)(B) of such Act (42 U.S.C. 1395e(b)(3)(B)) is amended by striking “inpatient hospital services” and inserting “inpatient hospital services, inpatient rural primary care hospital services”.

(4) Section 1861(a) of such Act (42 U.S.C. 1395x(a)) is amended—

(A) in paragraph (1), by striking “inpatient hospital services” and inserting “inpatient hospital services, inpatient rural primary care hospital services”; and

(B) in paragraph (2), by striking “hospital” and inserting “hospital or rural primary care hospital”.

(l) AUTHORIZATION OF APPROPRIATIONS.—Section 1820(l) of such Act (42 U.S.C. 1395i-4(l)), as redesignated by subsection (c)(2)(A), is amended by striking “Trust Fund” and all that follows and inserting the following:

“(1) for each of the fiscal years 1990 through 1994—

“(A) \$10,000,000 for grants to States under subsection (a)(1), and

“(B) \$15,000,000 for grants to hospitals, facilities, and consortia under subsection (a)(2); and

“(2) for each of the fiscal years 1995 through 1999—

“(A) \$50,000,000 for grants to States under subsection (a)(1), and

“(B) \$40,000,000 for grants to hospitals, facilities, and consortia under subsection (a)(2).”.

(m) EFFECTIVE DATE.—Except as otherwise provided, the amendments made by this section shall take effect on the date of the enactment of this Act.

SEC. 7202. COMMUNITY HEALTH NETWORK GRANT PROGRAM.

(a) IN GENERAL.—Part A of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

“ASSISTANCE FOR COMMUNITY HEALTH NETWORKS

“SEC. 1821. (a) ESTABLISHMENT OF PROGRAM.—There is hereby established a program under which the Secretary—

“(1) shall make grants to States and units of local government to carry out the activities described in subsection (d)(1); and

“(2) shall make grants to eligible hospitals and facilities (or consortia of hospitals and facilities) to carry out the activities described in subsection (d)(2).

“(b) ELIGIBILITY OF STATES AND COMMUNITIES FOR GRANTS.—A State or unit of local government is eligible to receive a grant under subsection (a)(1) only if the State or unit of local government submits to the Secretary, at such time and in such form as the Secretary may require, an application containing such information and assurances as the Secretary may require, together with assurances that the State or unit of local government—

“(1) has developed, or is in the process of developing, a community health plan that—

“(A) provides for the creation of a community health network (as defined in subsection (f)) in the State or locality,

“(B) promotes the integration of the delivery of health care services in the State or locality,

“(C) improves access to hospital and other services (including primary care services) for residents in the State or locality,

“(D) in the case of a plan of a unit of local government, is approved by the State, but only if, at the time the unit of local government applies for the grant, the State in which the unit of local government is located is receiving (or has applied to receive) a grant under subsection (a)(1),

“(E) in the case of a plan of a State, addresses the needs of each area in the State which is an area—

“(i) designated by the Secretary as a health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act, or

“(ii) with a significant number of individuals who are members of a medically underserved population designated by the Secretary under section 330 of such Act, and

“(F) in the case of a plan of a State, takes into account the operation of any such plan of a unit of local government in the State receiving a grant under subsection (a)(1);

“(2) has developed (or intends to develop) the plan described in paragraph (1) in consultation with appropriate State and community hospital associations, public hospitals, and primary care associations, and in the case of a plan of a State, in consultation with local governments in the State; and

“(3) has designated, or is in the process of designating, nonprofit or public hospitals and facilities located in the State or locality as community health network providers (with the approval of the State in the case of designations by units of local government).

“(c) ELIGIBILITY OF HOSPITALS, FACILITIES, AND CONSORTIA FOR GRANTS.—

"(1) IN GENERAL.—A hospital or facility is eligible to receive a grant under subsection (a)(2) only if the hospital or facility—

"(A) is located in a State or locality receiving a grant under subsection (a)(1);

"(B) is designated as community health network provider by the State or unit of local government;

"(C) submits an application to the State or unit of local government at such time and containing such information and assurances as the Secretary may require; and

"(D) has received certification by the State or unit of local government that the receiving of such grant by the hospital or facility is consistent with the community health plan of the State or unit or local government and that the State or unit of local government has approved the application submitted under subparagraph (C).

"(2) TREATMENT OF CONSORTIA.—A consortium of hospitals or facilities each of which is part of the same community health network is eligible to receive a grant under subsection (a)(2) if each of its members would individually be eligible to receive such a grant.

"(d) ACTIVITIES FOR WHICH GRANT MAY BE USED.—

"(1) GRANTS TO STATES OR LOCAL GOVERNMENTS.—A State or unit of local government shall use a grant received under subsection (a)(1) to carry out activities relating to planning and implementing its community health plan.

"(2) GRANTS TO HOSPITALS, FACILITIES, AND CONSORTIA.—A hospital or facility shall use a grant received under subsection (a)(2) to finance the costs it incurs in becoming part of a community health network and in serving as part of such a network, including costs related to—

"(A) the development of primary care service sites;

"(B) the development of integrated information, billing, and reporting systems;

"(C) planning and needs assessments;

"(D) the recruitment and training and health professionals and administrative staff; and

"(E) conducting health promotion outreach activities for medically underserved populations in its service area.

"(e) DESIGNATION OF COMMUNITY HEALTH NETWORK PROVIDERS.—

"(1) IN GENERAL.—A State or unit of local government may designate a hospital or facility as a community health network provider only if—

"(A) the hospital or facility is a member of (or is in the process of becoming a member of) a community health network (as defined in subsection (f));

"(B) in the case of a facility other than a hospital, the facility is a primary care center described in paragraph (2); and

"(C) in the case of a hospital—

"(i) the hospital is a sole community hospital described in section 1886(d)(5)(D),

"(ii) the hospital is a rural referral center described in section 1886(d)(5)(C), or

"(iii) the hospital is described in section 1886(d)(5)(F), or would be described in such section if the hospital were a subsection (d) hospital (as defined in section 1886(d)(1)(B)).

"(2) PRIMARY CARE CENTER DEFINED.—In this subsection, the term 'primary care center' means—

"(A) a rural health clinic (as defined in section 1861(aa)(2)),

"(B) a Federally-qualified health center (as defined in section 1861(aa)(4)), or

"(C) a facility that would be a Federally-qualified health center but for its failure to meet the requirement described in section 329(f)(2)(G)(i) of the Public Health Service Act or the requirement described in section 330(e)(3)(G)(i) of such Act (relating to the composition of the facility's governing board), but only if the facility provides assurances to the State or unit of local government that consumers have significant input into the governance of the facility.

"(f) COMMUNITY HEALTH NETWORK DEFINED.—In this section, the term 'community health network' means a public or nonprofit entity that meets the following requirements:

"(1) The entity provides primary care services and acute care services, including health promotion, health maintenance, and disease prevention, either directly through its members or through contracts with other entities (under such limited circumstances as the Secretary may permit in regulations) in an area—

“(A) designated by the Secretary as a health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act, or

“(B) with a significant number of individuals who are members of a medically underserved population designated by the Secretary under section 330 of such Act.

“(2) The entity consists of—

“(A) at least one hospital that has been designated as a community health network provider under subsection (e);

“(B) at least 3 primary care centers (as described in subsection (e)(2)); and

“(C) at the election of the entity’s members, any other entities that provide primary care or other health care services.

“(3) The members of the entity have entered into an agreement under which—

“(A) each member agrees to provide appropriate emergency and medical support services to other members,

“(B) each member agrees to accept referrals from other members,

“(C) each hospital member has arrangements to provide staff privileges to physicians providing care for other members, and

“(D) each member has in effect (or is in the process of establishing) agreements with other members to share in the member’s communication system, including (where appropriate) the electronic sharing of patient data, medical records, and billing services.

“(g) **LIMIT ON AMOUNT OF GRANT TO HOSPITAL OR FACILITY.**—A grant made to a hospital or facility under subsection (a)(2) may not exceed \$200,000, except that the total amount of a grant awarded to a consortia of hospitals or facilities under such subsection may not exceed \$1,000,000.

“(h) **PAYMENTS FOR GRANTS TO HOSPITALS.**—

“(1) **IN GENERAL.**—The Secretary shall make payments from the Federal Hospital Insurance Trust Fund for grants to eligible hospitals under subsection (c)(1) for fiscal years 1996 through 1999, except that the amount of payments made for such grants in any fiscal year may not exceed \$80,000,000.

“(2) **DIRECT SPENDING.**—Amounts in the Federal Hospital Insurance Trust Fund are available to the Secretary for making grants under paragraph (1) (in addition to other purposes provided under law).”.

(b) **FUNDING FOR GRANTS TO STATES THROUGH CURRENT EACH PROGRAM.**—Section 1820(l) of the Social Security Act (42 U.S.C. 1395i-4(l)), as amended and redesignated by section 7201(c)(2)(A) and section 7201(l), is amended—

(1) in the heading, by striking “APPROPRIATIONS” and inserting “APPROPRIATIONS FOR EACH PROGRAM AND GRANTS TO STATES FOR COMMUNITY HEALTH NETWORK PROGRAM”; and

(2) in paragraph (2)(A), by striking “(a)(1), and” and inserting “(a)(1) and grants to States and units of local government under section 1821(a)(1).”.

(d) **EFFECTIVE DATE.**—The amendments made by this section shall take effect October 1, 1995.

SEC. 7203. CAPITAL FINANCING ASSISTANCE.

(a) **IN GENERAL.**—The Social Security Act is amended by adding after the title added by section 8001 the following new title:

“TITLE XXIV—CAPITAL FINANCING ASSISTANCE FOR SAFETY NET PROVIDERS.

“PART A—GENERAL PROVISIONS

“SEC. 2401. PAYMENTS TO HOSPITALS AND FACILITIES

“(a) **IN GENERAL.**—The Secretary, with the approval of the Capital Financing Trust Fund Board of Trustees described in section 2404(d) (hereafter in this title referred to as the “Trust Fund Board”), shall make payments during fiscal years 1995 through 1999, from amounts in the Capital Financing Trust Fund established under section 2404(a) (hereafter in this title referred to as the “Trust Fund”), for capital financing assistance to eligible hospitals and facilities whose applications for assistance have been approved under this title.

“(b) **GENERAL ELIGIBILITY REQUIREMENTS FOR ASSISTANCE.**—

“(1) **REQUIREMENTS FOR HOSPITALS.**—

“(A) **IN GENERAL.**—A hospital shall be generally eligible for capital financing assistance under this title if the hospital—

"(i) is designated as an essential access community hospital by the Secretary under section 1820(i)(1);

"(ii) is designated as a rural primary care hospital by the Secretary under section 1820(i)(2); or

"(iii) has a disproportionate patient percentage (as described in section 1886(d)(5)(F)(vi)) equal to or greater than 40 percent.

"(B) OWNERSHIP REQUIREMENTS.—In order to qualify for assistance under this title, a hospital must—

"(i) be owned or operated by a unit of State or local government;

"(ii) be a quasi-public corporation, defined as a private, nonprofit corporation or public benefit corporation which is formally granted one or more governmental powers by legislative action through (or is otherwise partially funded by) the State legislature, city or county council; or

"(iii) be a private nonprofit hospital.

"(2) REQUIREMENTS FOR NON-HOSPITAL FACILITIES.—A facility that is not a hospital shall be generally eligible for capital financing assistance under this title if the facility is a not-for-profit facility and is designated as a primary care center under section 1821(e)(2).

"(c) MEETING ADDITIONAL SPECIFIC CRITERIA.—Hospitals and facilities that are generally eligible for assistance under this title under subsection (b) may apply for the specific programs described in this title and must meet any additional criteria for participation in such programs.

"(d) ASSISTANCE AVAILABLE.—Capital financing assistance available under this title shall include loan guarantees, interest rate subsidies, matching loans and direct grants. Hospitals and facilities determined to be generally eligible for assistance under this title may apply for and receive more than one type of assistance under this title.

"SEC. 2402. APPLICATION FOR ASSISTANCE.

"(a) IN GENERAL.—No hospital or facility may receive assistance for a qualifying project under this title unless the hospital or facility—

"(1) has filed with the Secretary, in a form and manner specified by the Secretary, with the advice and approval of the Trust Fund Board (as described in section 2404(d)), an application for assistance under this title;

"(2) establishes in its application (for its most recent cost reporting period) that it meets the criteria for general eligibility under this title;

"(3) includes a description of the project, including the community in which it is located, and describes utilization and service characteristics of the project and the hospital or facility, and the patient population that is to be served;

"(4) in the case of a facility located in a State determined by the Secretary to have in effect a plan and process for the review and approval of capital expenditures, is in conformity with such plan and is approved under such process;

"(5) describes the extent to which the project is intended to include the financial participation of State and local governments, and all other sources of financing sought for the project; and

"(6) establishes, to the satisfaction of the Secretary and the Trust Fund Board, that the project meets the additional criteria for each type of capital financing assistance for which it is applying.

"(b) CRITERIA FOR APPROVAL.—The Secretary, with the approval of the Trust Fund Board, shall determine for each application for assistance under this title—

"(1) whether the hospital or facility meets the general eligibility criteria under section 2401(b);

"(2) whether the hospital or facility meets the specific eligibility criteria of each type of assistance for which it has applied, including whether the hospital or facility meets any criteria for priority consideration for the type of assistance for which it has applied;

"(3) whether the capital project for which assistance is being requested is a qualifying project under this title; and

"(4) whether funds are available, pursuant to the limitations of each program, to fully fund the request for assistance.

"(c) PRIORITY OF APPLICATIONS.—In addition to meeting the criteria otherwise described in this title, at the discretion of the Trust Fund Board, the Secretary shall give preference to those qualifying projects that—

"(1)(A) are necessary to bring safety net facilities into compliance with accreditation standards or fire and life safety, seismic, or other related Federal, State or local regulatory standards;

"(B) improve the provision of essential services such as emergency medical and trauma services, AIDS and infectious disease, perinatal, burn, primary care, and other services which the Trust Fund's Board may designate; or

"(C) will result in the provision of access to essential health services (as designated by the Board of the Trust Fund) to indigent and other needy persons within the hospital's or facility's service area that would otherwise be unavailable;

"(2) include specific anticipated State or local governmental or other non-Federal assurances of financial support;

"(3) are unlikely to be financed without the assistance provided under this title; and

"(4) are conducted by entities designated as community health network providers under section 1821.

"(d) SUBMISSION OF APPLICATIONS.—Applications under this Act shall be submitted to the Secretary through the Trust Fund Board. If two or more applicants join in the project, the application shall be submitted by all participating hospitals and facilities jointly. Such applications shall set forth all of the descriptions, plans, specifications, and assurances as required by this Act and contain other such information as the Trust Fund Board shall require.

"(e) OPPORTUNITY FOR APPEAL.—The Trust Fund Board shall afford a hospital or facility applying for a loan guarantee under this section an opportunity for a hearing if the guarantee is denied.

"(f) APPLICATIONS FOR AMENDMENTS.—Amendment of an approved application shall be subject to approval in the same manner as an original application.

"SEC. 2403. PUBLIC SERVICE RESPONSIBILITIES.

"Any hospital or facility accepting capital financing assistance under this title shall agree to provide a significant volume of services to persons who are not eligible individuals under title I of the Health Security Act.

"SEC. 2404. CAPITAL FINANCING TRUST FUND.

"(a) CREATION OF TRUST FUND.—There is established in the Treasury of the United States a trust fund to be known as the Capital Financing Trust Fund, consisting of such amounts as may be appropriated or credited to such Trust Fund as provided in this section.

"(b) TRANSFERS TO TRUST FUND.—

"(1) IN GENERAL.—There are hereby appropriated to the Trust Fund for each of the fiscal years 1996 through 1999 amounts equivalent to such amount as the Secretary determines is necessary to enable the Trust Fund to make all required expenditures during a year (subject to the limitations provided under this title on the amounts which may be expended under this title). Such amounts shall be transferred from time to time (but not less often than monthly) from the general fund in the Treasury to the Trust Fund.

"(2) DIRECT SPENDING.—Amounts appropriated under paragraph (1) to the Trust Fund are available each fiscal year to the Secretary for carrying out this title.

"(c) EXPENDITURES FROM TRUST FUND.—Amounts in the Trust Fund shall be available only—

"(1) for making expenditures to carry out this title; and

"(2) for grants to non-hospital facilities and consortia under section 1821(a)(2) for fiscal years 1995 through 1999, except that not more than \$80,000,000 may be available for such grants for any fiscal year.

"(d) BOARD OF TRUSTEES; COMPOSITION; MEETINGS; DUTIES.—

"(1) IN GENERAL.—There shall be created a Capital Financing Trust Fund Board of Trustees composed of the Secretary of Health and Human Services, the Secretary of the Treasury, the Assistant Secretary for Health, and the Administrator of the Health Care Financing Administration (all serving in their ex officio capacities), and 5 public members who shall be appointed for 4 year terms by the President, from the following categories—

"(A) one chief health officer from a State;

"(B) one chief executive officer of a hospital or facility that meets the general eligibility criteria of this title;

"(C) one representative of the financial community; and

"(D) two additional public or consumer representatives.

"(2) DUTIES.—The Board of Trustees shall meet no less than quarterly and shall have the responsibility to approve implementing regulations, to establish criteria, and to recommend and approve expenditures by the Secretary under the programs set forth in this title.

"(3) MANAGING TRUSTEE.—The Secretary of the Treasury shall serve as the Managing Trustee of the Trust Fund, and shall be responsible for the investment of funds. The provisions of subsections (b) through (e) of section 1817 shall apply to the Trust Fund and the Managing Trustee of the Trust Fund in the same manner as they apply to the Federal Hospital Insurance Trust Fund and the Managing Trustee of that Trust Fund.

"SEC. 2405. ADMINISTRATION.

"(a) IN GENERAL.—The Administrator of the Health Care Financing Administration shall serve as Secretary of the Board of Trustees and shall administer the programs under this title.

"(b) LIMITATION ON ADMINISTRATIVE EXPENSES.—Not more than 5 percent of the funds annually appropriated to the Trust Fund may be available for administration of the Trust Fund or programs under this title.

"PART B—LOAN GUARANTEES

"SEC. 2410. PROVISION OF LOAN GUARANTEES TO SAFETY NET PROVIDERS.

"(a) IN GENERAL.—Subject to the annual limitation on the allotment from the Trust Fund described in section 2412(a), the Capital Financing Trust Fund will provide a Federal guarantee of loan repayment, including guarantees of repayment of refinancing loans, to non-Federal lenders making loans to qualified hospitals and facilities for replacement (either by construction or acquisition), modernization, and renovation projects and capital equipment acquisitions.

"(b) PURPOSES.—The loan guarantee program shall be designed by the Trust Fund Board with the goal of rebuilding and maintaining the essential health services of hospitals and facilities eligible for assistance under this title.

"SEC. 2411. ELIGIBLE LOANS.

"(a) IN GENERAL.—Loan guarantees under this part are available for loans made to qualifying hospitals and facilities for replacement facilities, the modernization and renovation of existing facilities, and capital equipment acquisitions.

"(b) LOAN GUARANTEE MUST BE ESSENTIAL TO FINANCING.—Qualifying hospitals and facilities must demonstrate that a Federal loan guarantee is essential to obtaining financing from non-Federal lenders at a reasonably affordable rate of interest.

"(c) ADDITIONAL ELIGIBILITY CRITERIA FOR LOAN GUARANTEES.—In order to qualify for assistance under this part, a hospital or facility must meet the following criteria:

"(1) The hospital or facility must demonstrate evidence of an ability to meet debt service.

"(2) The assistance, when considered with other resources available to the project, is necessary and will restore, maintain, or improve the financial or physical soundness of the hospital or facility.

"(3) The applicant agrees to assume the public service responsibilities described in section 2403.

"(4) The project is being operated and managed (or will be operated and managed) in accordance with a management-improvement-and-operating plan which is designed to reduce the operating costs of the project, which has been approved by the Trust Fund Board, and which includes—

"(A) a detailed maintenance schedule;

"(B) a schedule for correcting any past deficiencies in maintenance, repairs, and replacements;

"(C) a plan to upgrade the project to meet cost-effective energy efficiency standards prescribed by the Trust Fund Board;

"(D) a plan to improve financial and management control systems;

"(E) a detailed annual operating budget taking into account such standards for operating costs in the area as may be determined by the Trust Fund Board; and

"(F) such other requirements as the Trust Fund Board may determine.

"(5) The application includes stringent provisions for continued State or local support of the program, both with respect to operating and financial capital.

"(6) The terms, conditions, maturity, security (if any), and schedule and amount of repayments with respect to the loan are sufficient to protect the financial interests of the United States and are otherwise reasonable and in accord with regulation, including a determination that the rate of interest does not exceed such annual percentage on the principal obligation outstanding as the Trust Fund Board determines to be reasonable, taking into account the range of interest rates prevailing in the private market for similar loans and the risks assumed by the United States.

"(7) The hospital or facility must meet such other additional criteria as the Secretary may impose.

"(d) STATE OR LOCAL PARTICIPATION.—Projects in which State or local governmental entities participate in the form of first guarantees of part or all of the total loan value shall be given a preference for loan guarantees under this part.

"SEC. 2412. GUARANTEE ALLOTMENTS.

"(a) IN GENERAL.—Not more than \$150,000,000 shall be annually allocated from the Trust Fund for purposes of the loan guarantee program established by this part.

"(b) LOAN GUARANTEES FOR RURAL HOSPITALS AND FACILITIES.—At least 10 percent of the dollar value of loan guarantees made under this program during any given year shall be allocated for eligible rural hospitals and facilities, to the extent a sufficient number of applications made by such hospitals and facilities is approved.

"(c) SPECIAL RULE FOR REFINANCING LOANS.—Not more than 20 percent of the amount allocated each year to the loan guarantee program established by this part may be allocated to guarantee refinancing loans during the year.

"SEC. 2413. TERMS AND CONDITIONS OF LOAN GUARANTEES.

"(a) IN GENERAL.—The principle amount of the guaranteed loan, when added to any Federal grant assistance made under this title, may not exceed 95 percent of the total value of the project, including land.

"(b) GUARANTEES PROVIDED MAY NOT SUPPLANT OTHER FUNDS.—Guarantees provided under this part may not be used to supplant other forms of State or local support.

"(c) RIGHT TO RECOVER FUNDS.—The United States shall be entitled to recover from any applicant the amount of payments made pursuant to any loan guarantee under this part, unless the Trust Fund Board for good cause waives its right of recovery, and, upon making any such payment, the United States shall be subrogated to all of the rights of the recipients of the payments with respect to which the guarantee was made.

"(d) MODIFICATION OF TERMS.—Loan guarantees made under this part shall be subject to further terms and conditions as the Trust Fund Board determines to be necessary to assure that the purposes of this Act will be achieved, and any such terms and conditions may be modified by the Trust Fund Board to the extent that it determines such modifications to be consistent with the financial interest of the United States.

"(e) TERMS ARE INCONTESTABLE ABSENT FRAUD OR MISREPRESENTATION.—Any loan guarantee made by the Trust Fund Board pursuant to this part shall be incontestable in the hands of an applicant on whose behalf such guarantee is made, and as to any person who makes or contracts to make a loan to such applicant in reliance thereon, except for fraud or misrepresentation on the part of such applicant or other person.

"SEC. 2414. PREMIUMS FOR LOAN GUARANTEES.

"(a) IN GENERAL.—The Trust Fund Board shall determine a reasonable loan insurance premium which shall be charged for loan guarantees under this part, taking into account the availability of the reserves created under section 2412. Premium charges shall be payable in cash to the Trust Fund (either in full upon issuance or annually in advance). In addition to the premium charge herein provided for, the Trust Fund is authorized to charge and collect such amount as it may deem reasonable for the appraisal of a property or project offered for insurance and for the inspection of such property or project.

"(b) PAYMENT IN ADVANCE.—In the event that the principal obligation of any loan accepted for insurance under this part is paid in full prior to the maturity date, the Trust Fund Board is authorized in its discretion to require the payment by the borrower of an adjusted premium charge in such amount as the Board determines to be equitable, but not in excess of the aggregate amount of the premium charges that the hospital or facility would otherwise have been required to pay if the loan had continued to be insured until maturity date.

"(c) TRUST FUND BOARD MAY WAIVE PREMIUMS.—The Trust Fund Board may in its discretion partially or totally waive premiums charged for loan insurance under this section for financially distressed hospitals and facilities (as described by the Secretary).

"SEC. 2415. PROCEDURES IN THE EVENT OF LOAN DEFAULT.

"(a) PAYMENT OF INSURANCE AFTER DEFAULT.—

"(1) TRANSFER OF RIGHTS AND INTERESTS.—The failure of the borrower hospital or facility to make payment due under or provided by the terms of a loan

insured under this part shall be considered in default under such loan and, if such default continues for a period of 30 days, the lender shall be entitled to receive the benefits of the insurance as hereinafter provided, upon assignment, transfer, and delivery to the Trust Fund Board, within a period and in accordance with rules and regulations to be prescribed by the Trust Fund Board of—

“(A) all rights and interests arising under the loan in default;

“(B) all claims of the lender against the borrower or others, arising out of the loan transactions;

“(C) all policies of title or other insurance or surety bonds or other guarantees and any and all claims thereunder;

“(D) any balance of the loan not advanced to the borrower;

“(E) any cash or assets held by the lender, or to which it is entitled, as deposits made for the account of the borrower and which have not been applied in reduction of the principal of the loan indebtedness; and

“(F) all records, documents, books, papers, and accounts relating to the mortgage transaction.

“(2) PAYMENTS BY TRUST FUND.—Upon an assignment, transfer, and delivery described in paragraph (1), the obligation of the borrower to pay the premium charges for the loan insurance shall cease, and the Trust Fund shall, subject to the cash adjustment provided for in subsection (d), issue to the lender a certificate of claim as provided in subsection (b), and debentures having total face value equal to the original principal face amount of the loan plus such amount as the borrower may have paid for taxes, special assessments, and water rates, which are liens prior to the mortgage; insurance on the assets; and reasonable expenses for the completion and preservation of the assets and any loan insurance premiums paid after default, less the sum of—

“(A) that part of the amount of the principal obligation that has been repaid by the borrower,

“(B) an amount equivalent to 1 percent of the unpaid amount of such principal obligation, and

“(C) any net income received by the lender from the assets.

“(3) OPTION TO FORECLOSE.—

“(A) IN GENERAL.—In the event of a default under the loan the lender may, at its option and in accordance with the regulations of, and in a period of time to be determined by the Trust Fund Board, proceed to foreclose on and obtain possession of or otherwise acquire such assets from the borrower after default, and receive the benefits of the insurance as herein provided, upon—

“(i) the prompt conveyance to the Trust Fund of title to the assets which meets the requirements of the rules and regulations of the Trust Fund Board in force at the time the loan was insured and which is evidenced in the manner prescribed by such rules and regulations; and

“(ii) the assignment to the Trust Fund of all claims of the lender against the borrower or others, arising out of the loan transaction or foreclosure proceedings, except such claims that may have been released with the consent of the Trust Fund Board.

“(B) REPEAL OF OBLIGATION TO PAY PREMIUM.—Upon such conveyance and assignment, the obligation of the borrower to pay the premium charges for insurance shall cease and the borrower shall be entitled to receive the benefits of the insurance as provided in this subsection, except that in such event the 1 percent deduction set out above shall not apply.

“(b) CERTIFICATE OF CLAIM; DIVISION OF EXCESS PROCEEDS.—

“(1) VALUE OF CERTIFICATE.—The certificate of claim issued under this section shall be for an amount which the Trust Fund Board determines to be sufficient, when added to the face value of the debentures issued and the cash adjustment paid to the lender, to equal the amount which the lender would have received if, on the date of the assignment, transfer and delivery to the Trust Fund provided for in subsection (a) of this section, the mortgagor had extinguished the mortgage indebtedness by payment in full of all obligations under the loan and a reasonable amount for necessary expenses incurred by the lender in connection with the default proceedings, or the acquisition of the mortgaged assets otherwise, and the conveyance thereof to the Trust Fund. Each such certificate of claim shall provide that there shall accrue to the holder of such certificate with respect to the face amount of such certificate, an increment at the rate of 3 percent per annum which shall not be compounded.

“(2) TREATMENT OF EXCESS.—If the net amount realized from the mortgage, and all claims in connection therewith, so assigned, transferred, and delivered, and from the assets covered by such mortgage and all claims in connection with

such assets, after deducting all expenses incurred by the Trust Fund in handling, dealing with, acquiring title to, and disposing of such mortgage and assets and in collecting such claims, exceeds the face value of the debentures issued and the case adjustment paid to the mortgagee plus all interest paid on such debentures, such excess shall be divided as follows:

“(A) If such excess is greater than the total amount payable under the certificate of claim issued in connection with such assets, the Trust Fund shall pay to the holder of such certificate the full amount so payable, and any excess remaining thereafter shall be retained by the Trust Fund and credited to the loan insurance program of the Trust Fund.

“(B) If such excess is equal to or less than the total amount payable under such certificate of claim, the Trust Fund Board shall pay to the holder of such certificate the full amount of such excess.

“(c) ACQUISITION OF ASSETS BY CONVEYANCE OR FORECLOSURE.—

“(1) IN GENERAL.—The Trust Fund Board is authorized to—

“(A) acquire possession of and title to any assets, covered by a mortgage insured under this section and assigned to it, by voluntary conveyance in extinguishment of the mortgage indebtedness, or

“(B) institute proceeding for foreclosure on the assets covered by any such insured mortgage and prosecute such proceedings to conclusion.

“(2) BIDDING PROCEDURES AT FORECLOSURE.—The Trust Fund Board at any sale under foreclosure may, in its discretion, for the protection of the Trust Fund, bid any sum up to but not in excess of the total unpaid indebtedness secured by the mortgage plus taxes, insurance, foreclosure costs, fees, and other expenses, and may become the purchaser of the assets at such sale. In determining the amount to be bid, the Trust Fund Board shall act consistently with its duties.

“(3) PAYMENT OF EXPENSES.—The Trust Fund Board is authorized to pay from the Trust Fund such sums as may be necessary to defray such taxes, insurance, costs, fees, and other expenses in connection with the acquisition or foreclosure of assets under this section.

“(4) EXERCISE OF RIGHTS PENDING ACQUISITION.—Pending such acquisition by voluntary conveyance or by foreclosure, the Trust Fund Board is authorized, with respect to any mortgage assigned to it under the provisions of subsection (a), to exercise all the rights of a mortgagee under such mortgage, including the right to sell such a mortgage, and to take such action and advance such sums as may be necessary to preserve or protect the lien of such mortgage.

“(d) HANDLING AND DISPOSAL OF ASSETS; SETTLEMENT OF CLAIMS.—

“(1) PAYMENT FOR CERTAIN EXPENSES.—Notwithstanding any other provisions of law relating to the acquisition, handling, or disposal of real and other property by the United States, the Trust Fund Board shall also have power, for the protection of the interests of the Trust Fund, to pay out of the Trust Fund all expenses or charges in connection with, and to deal with, complete, reconstruct, rent, renovate, modernize, insure, make contracts for the management of, or establish suitable agencies for the management of, or sell for cash or credit or lease in its discretion, any assets acquired by it under this section.

“(2) SETTLEMENT OF CLAIMS.—Notwithstanding any other provision of law, the Trust Fund Board shall also have the power to pursue to final collection by way of compromise or otherwise all claims assigned and transferred to it in connection with the assignment, transfer, and delivery provided for in this section, and at any time, upon default, to foreclose or refrain from foreclosing on any assets secured by any mortgage assigned and transferred to or held by it.

“(3) LIMITATIONS ON AUTHORITY.—Subsections (a) and (b) shall not be construed to apply to any contract for hazard insurance, or to any purchase or contract for services or supplies on account of such assets if the amount thereof does not exceed \$1,000.

“PART C—INTEREST RATE SUBSIDIES

“SEC. 2421. PROVISION OF INTEREST RATE SUBSIDIES.

“(a) IN GENERAL.—The Secretary, with the approval of the Trust Fund Board, shall make available interest subsidies to reduce the cost of financing qualifying projects.

“(b) PURPOSES.—The interest subsidy program shall provide a partial Federal subsidy of debt service payment for financing replacement (whether by construction or acquisition), modernization, and renovation projects or capital equipment acquisitions.

"SEC. 2422. ELIGIBLE LOANS.

"(a) IN GENERAL.—Qualifying hospitals and facilities should have issued or plan to issue bonds, or should have secured or plan to secure loans, for capital projects or be responsible for paying debt service on general obligation or revenue bonds issued or loans made on the qualifying hospital's or facility's behalf. To be eligible, bonds must have been issued after December 31, 1992.

"(b) NON-FEDERAL PARTICIPATION REQUIREMENT.—In order to obtain assistance under this part, a hospital or facility must receive assistance from non-Federal sources in an amount not less than the amount of the assistance provided under this part.

"SEC. 2423. ALLOTMENT OF SUBSIDIES.

"(a) IN GENERAL.—Interest subsidy grants will be made in the amount of 3 percent for qualifying non-Federal loans.

"(b) QUALIFYING FEDERAL LOANS MADE UNDER THIS ACT.—Interest subsidy grants in an amount of up to 5 percent will be made for qualifying Federal loans made under this title if it is determined by the Trust Fund Board that the project would not be otherwise financially feasible.

"(c) RESERVE FOR RURAL HOSPITALS AND FACILITIES.—At least 10 percent of the total value of all interest subsidies awarded in any given year shall be awarded to rural hospitals and facilities, provided that a sufficient number of applications are approved.

"(d) LIMITATION ON AMOUNT OF SUBSIDIES AWARDED IN A GIVEN STATE.—The aggregate value of interest subsidies made to hospitals and facilities in any State in a given year shall not exceed 25 percent of the total value of all interest subsidies made during that year.

"(e) AMOUNT ALLOCATED FROM TRUST FUND.—The Trust Fund Board shall make available \$220,000,000 annually for interest subsidies under this part.

"SEC. 2424. TERMS AND CONDITIONS FOR SUBSIDIES.

"(a) STATE OR LOCAL PARTICIPATION.—State or local participation in an amount equal to not less than the Federal subsidy is required.

"(b) ISSUANCE OF FEDERAL COMMITMENTS.—Successful applicants will receive a Federal commitment of interest subsidy grant. Applicants will then have 12 months to finalize financing arrangements before unobligated funds would be returned to the subsidy program pool. A commitment, when issued, shall be valid for as long as a hospital or facility continues to meet the eligibility qualifications of this title.

"SEC. 2425. SUBSIDIES FOR LOAN REFINANCING.

"In addition to providing interest rate subsidies for new loans, the Trust Fund may provide subsidies to assist in refinancing if the hospital or facility presently lacks permanent financing at an affordable current market rate.

"PART D—DIRECT MATCHING LOANS**"SEC. 2431. PROVISION OF MATCHING LOANS.**

"(a) IN GENERAL.—The Secretary, with the approval of the Trust Fund Board, shall provide direct matching loans to qualified hospitals and facilities unable otherwise to obtain essential financing.

"(b) PURPOSES.—The purpose of this part is to provide qualifying hospitals and facilities with direct matching loans for essential replacement (whether by construction or acquisition), modernization, and renovation projects and capital equipment acquisitions. These loans are to be primarily provided for the funding of smaller projects where the transaction costs of securing financing from other sources may be disproportionately onerous in relationship to the amounts financed.

"SEC. 2432. ELIGIBLE PROJECTS.

"(a) IN GENERAL.—Qualified applicants may seek a project loan of up to \$50,000,000. Not more than 75 percent of the cost of the project may come from Federal sources.

"(b) EXCEPTION FOR FINANCIALLY DISTRESSED APPLICANTS.—The Trust Fund Board shall have the discretion to waive the 25 percent match requirement for financially distressed hospitals and facilities (as described by the Secretary).

"SEC. 2433. ALLOTMENT OF LOANS.

"(a) IN GENERAL.—The Trust Fund Board shall make available \$200,000,000 in direct matching loans annually. Funded projects should be divided between projects designed to achieve compliance with accreditation standards, life safety code, and other certification standards, and those related to the provision of new services.

"(b) RESERVE FOR RURAL HOSPITALS AND FACILITIES.—No less than 10 percent of the total value of loans made under the program shall be made to rural hospitals and facilities, if there are a sufficient number of approved applications from such hospitals and facilities.

"SEC. 2434. TERMS AND CONDITIONS OF LOANS.

"(a) GENERAL TERM.—Loans will be made for a period equal to the construction period plus up to 39 years amortization.

"(b) INTEREST RATE.—The interest rate will be a market rate determined by the Trust Fund Board to be the most recent applicable index for revenue bonds, as the Board finds appropriate.

"SEC. 2435. USE OF LOANS FOR REFINANCING.

"In addition to providing loans for new projects, the Trust Fund Board may grant loans under this part to refinance existing loans if the hospital or facility has been unable to secure permanent financing at an affordable current market rate, except that the amount of assistance provided under this part during a year for refinancing existing loans may not exceed 20 percent of the total amount made available for assistance under this part for the year.

"SEC. 2436. CREATION OF REVOLVING FUND.

"In addition to the new amounts made available each year, all loan repayments made by hospitals and facilities shall be held in a revolving fund that may be used for additional loans.

"SEC. 2437. LOAN DEFAULT.

"(a) IN GENERAL.—The failure of the borrower hospital or facility to make payment due under or provided by the terms of a loan granted under this part shall be considered a default under such loan and, if such default continues for a period of 30 days, the Trust Fund Board shall have the right to begin collection proceedings against the borrower.

"(b) PRIORITY OF FEDERAL INTEREST.—In the case of default, the United States shall be paid prior to State or local bonds.

"(c) SETTLEMENT OF CLAIMS.—Notwithstanding any other provision of law, the Trust Fund Board shall have the power to pursue to final collection by way of compromise or otherwise all claims assigned and transferred to the Trust Fund in connection with an assignment, transfer, and delivery and at any time, upon default, to foreclose or refrain from foreclosing on any assets secured by any defaulted loan held by the Trust Fund.

"PART E—GRANTS FOR URGENT CAPITAL NEEDS

"SEC. 2441. PROVISION OF GRANTS.

"(a) IN GENERAL.—The Secretary, with the approval of the Trust Fund Board, shall make direct grants to qualified hospitals and facilities with urgent capital needs.

"(b) PURPOSES.—Direct grants shall be available to eligible hospitals and facilities for 3 types of projects:

"(1) Emergency certification and licensure grants would be available to eligible hospitals and facilities that are threatened with closure or loss of accreditation or certification of a facility or of essential services as a result of life or safety code violations or similar facility or equipment failures. Such grants would provide limited funding for repair and renovation or capital equipment acquisition where failure to fund would disrupt the provision of essential public health services such as emergency care.

"(2) Emergency grants would be available for capital renovation, expansion, or replacement (whether by construction or acquisition) necessary to the maintenance or expansion of essential safety and health services such as obstetrics, perinatal, emergency and trauma, primary care and preventive health services.

"(3) Planning grants would be available to qualified hospitals and facilities requiring pre-approval assistance related to management and finance in order to apply for loans, loan guarantees, and interest subsidies under this title.

"(c) PRIORITY TO FINANCIALLY DISTRESSED PROVIDERS.—Priority for direct grants under this section would be given to financially distressed hospitals and facilities (as described by the Secretary).

"(d) APPLICATION PROCESS.—The Secretary, with the approval of the Trust Fund Board, shall create an expedited application process for direct grants.

"(e) AMOUNT ALLOCATED FROM TRUST FUND.—The Trust Fund Board shall annually allocate \$410,000,000 from the Trust Fund for grants under this part.

"SEC. 2442. ELIGIBLE PROJECTS.**"(a) MATCHING GRANTS.—**

"(1) LIMITATION ON AMOUNT.—Grants for capital expenditures by qualified hospitals and facilities will be limited to \$25,000,000.

"(2) MATCHING REQUIREMENT.—At least half of the projects funded in a year must receive at least 50 percent of their funding from State or local sources. The remaining projects funded during the year could be financed up to 90 percent with a combination of Federal grants and loans.

"(3) RESERVATION FOR RURAL APPLICANTS.—No less than 10 percent of the grant funds in any given year would be reserved for rural applicants, provided that a sufficient number of applications are approved.

"(b) PLANNING GRANTS.—

"(1) IN GENERAL.—Applicants who can demonstrate general qualification for the direct matching loan, loan guarantee, or interest subsidy programs under this title will be eligible for a grant of up to \$200,000 to assist in implementation of key budgetary and financial systems as well as management and governance restructuring.

"(2) LIMIT ON TOTAL AMOUNTS PROVIDED.—The total amount of assistance provided under this part in the form of planning grants described in this subsection shall not exceed \$10,000,000.

"PART F—TRANSITIONAL ASSISTANCE FOR ACADEMIC HEALTH CENTERS**"SEC. 2451. PROVISION OF INTEREST RATE SUBSIDIES.**

"The Secretary, with the approval of the Trust Fund Board, shall make available interest subsidies to reduce the cost of financing eligible major facility replacement projects of eligible hospitals.

"SEC. 2452. ELIGIBLE FINANCING.

"(a) IN GENERAL.—An interest subsidy is available under this part with respect to any financing obtained by the hospital if the financing meets the requirements of subsections (b) through (d), without regard to whether such financing is subject to refunding, advance refunding, or refinancing.

"(b) PROPORTION OF AGGREGATE FINANCING USED FOR PROJECT.—An interest subsidy is available under this part with respect to any financing obtained for a project only if not less than 80 percent of all financing for which a subsidy is provided under this part with respect to the project is used for such project.

"(c) LIMIT ON TOTAL AMOUNT OF FINANCING ELIGIBLE FOR SUBSIDY.—The total amount of financing for which a subsidy is provided under this part with respect to a project may not exceed the lesser of—

"(1) 65 percent of the total cost of the project, as specified by the governing board of the hospital prior to June 1, 1994;

"(2) the total amount of borrowing authorized by the governing board of the hospital with respect to the project prior to June 1, 1994; or

"(3) the Secretary's estimate of the reasonable cost of such financing, as determined in accordance with the methodology described in section 1861(v).

"(d) PROHIBITION AGAINST USE OF SUBSIDY FOR RETROACTIVE DEBT SERVICE PAYMENTS.—The Secretary may not provide any interest subsidy under this part with respect to any debt service payment made by a hospital prior to the date on which the subsidy is initially provided to the hospital under this part.

"SEC. 2453. ELIGIBILITY OF HOSPITALS AND PROJECTS.

"(a) HOSPITALS.—A hospital is eligible to receive an interest subsidy under this part if the hospital—

"(1) is eligible to receive payment for the direct costs of graduate medical education under section 1886(h);

"(2) on June 1, 1994, was eligible to receive a payment adjustment under section 1886(d)(5)(F) in an amount determined in accordance with section 1886(d)(5)(F)(vii)(I); and

"(3) is a public or nonprofit hospital.

"(b) PROJECTS.—

"(1) IN GENERAL.—A major facility replacement project of a hospital is eligible under section 2451(a) if—

"(A) prior to June 1, 1994, the project has been approved by a State under a capital review program or, in the case of a project in a State without such a program, by the governing board of the hospital;

"(B) the hospital demonstrates that the replacement facility will be available for providing services to patients not later than December 31, 2002 and

was not available for providing services to patients prior to January 1, 1987; and

“(C) the total cost of the project is not less than \$500,000,000.

“(2) TOTAL PROJECT COST DEFINED.—In paragraph (1)(C), the term ‘total project cost’ means the total amount of project-related costs, including the following: construction; land; air rights; equipment; construction contingency; planning; legal, architectural, engineering, and design services; interest during construction; borrowings for the purpose of refinancing previously incurred debt in order to meet requirements of a new lender; and other expenses generally recognized as costs of development, financing, and construction of such projects.

“SEC. 2454. ALLOTMENT OF SUBSIDIES.

“(a) IN GENERAL.—Interest subsidy grants to a hospital under this part will be made in an amount not to exceed 3 percentage points, except that the amount of such a grant may not exceed the interest portion of the eligible financing involved.

“(b) AMOUNT ALLOCATED FROM TRUST FUND.—The Trust Fund Board shall make available \$50,000,000 annually for interest subsidies under this part. If such amount is insufficient to provide interest subsidies to all eligible applicants, the amount of the subsidy provided to each recipient shall be reduced on a pro rata basis.”.

(b) ADJUSTMENT TO PAYMENTS FOR CAPITAL-RELATED COSTS UNDER MEDICARE.—Section 1886(g)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(g)(1)(B)) is amended—

(1) by striking “and” at the end of clause (iii);

(2) by striking the period at the end of clause (iv) and inserting “, and”; and

(3) by adding at the end the following new clause:

“(v) shall provide for adjustments to take into account the extent to which capital-related costs incurred by a hospital are costs with respect to which the hospital received financial assistance under title XXIV.”.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect October 1, 1994.

Subtitle D—Lead Paint Abatement

SEC. 7301. ALLOTMENTS FOR STATES AND CERTAIN POLITICAL SUBDIVISIONS.

(a) IN GENERAL.—

(1) STANDARD ALLOTMENTS.—The Secretary shall, for fiscal year 1995 and each subsequent fiscal year, make a standard allotment for each eligible public entity in the amount determined in accordance with section 7309(b).

(2) TOTAL ALLOTMENTS.—The Secretary shall, for each of such years, make a total allotment for each eligible public entity for which the amount of the standard allotment for such entity for the year exceeds \$250,000. The amount of the total allotment shall be determined in accordance with section 7309(a).

(3) CONTRACTS.—For the purposes described in section 7304, in each of such fiscal years, the Secretary shall enter into a contract with each eligible public entity for which a total allotment is made for such year, under which contract the amount of the total allotment made for the entity for such year is paid to the entity.

(4) INELIGIBILITY BECAUSE OF INSUFFICIENT STANDARD ALLOTMENT.—If the amount of the standard allotment for an eligible public entity is equal to or less than \$250,000, the entity shall not receive a contract under this section for the fiscal year and the standard allotment for the entity shall be terminated for the fiscal year.

(b) ELIGIBLE PUBLIC ENTITIES.—For purposes of this subtitle, the term “eligible public entity” means any public entity that—

(1) submits to the Secretary for the fiscal year involved a plan in accordance with section 7307(a) that is approved by the Secretary under section 7307(b);

(2) is—

(A) a State;

(B) a city that has a population of 100,000 or more individuals;

(C) an urban county (excluding the population of any such city therein that has so submitted such a plan); or

(D) a consortium of smaller communities that are not entities described in subparagraph (A), (B), or (C) that—

(i) submits the plan under section 7307(a) as a consortium; and

(ii) meets such other requirements as the Secretary may establish;

(3) has an authorized program under section 404 of the Toxic Substances Control Act, or is located in a State that has such a program;

(4) has submitted to the Secretary a comprehensive housing affordability strategy under section 105 of the Cranston-Gonzalez National Affordable Housing Act that includes the information required by section 105(b)(16) of such Act (as added by section 1014 of the Housing and Community Development Act of 1992, Public Law 102-550, relating to information on lead-based paint hazards) and has not had such strategy disapproved for the year involved because of failure to provide sufficient information under such section 105(b)(16); and

(5) for any public entity that is a city or urban county, has in effect, for the entire jurisdiction of the public entity, local lead-based paint laws.

SEC. 7302. LEAD ABATEMENT PROGRAM ACCOUNT; REQUIRED PAYMENTS.

(a) PROGRAM ACCOUNT.—

(1) IN GENERAL.—The Secretary shall award contracts under section 7301 only with amounts available in the Lead Abatement Program Account (established under section 9512 of the Internal Revenue Code of 1986). Any amounts in the Account on October 1 of a fiscal year that remain after amounts are reserved pursuant to section 7312 shall be allotted for contracts in accordance with section 7301. Any amounts credited to the Account during the period of such fiscal year occurring after October 1 shall not be available for allotment during such period.

(2) EXPENDITURES FROM ACCOUNT.—Amounts in the Account shall be available for purposes of awarding contracts under sections 7301 and 7309(d) and for administrative cost as provided in section 7312, but shall not be available for any other purpose.

(b) REQUIRED PAYMENTS.—

(1) IN GENERAL.—Subject to subsection (c), the Secretary shall award contracts under section 7301 for fiscal year 1995 and each subsequent fiscal year.

(2) RULE OF CONSTRUCTION.—Paragraph (1) may not be construed to establish, with respect to this section, an entitlement of any individual to have carried out on behalf of the individual any activity authorized in section 7304.

(c) LIMITATIONS.—The requirement for the Secretary to award a contract under section 7301 to an eligible public entity applies—

(1) only to the extent that there are amounts in the Account and only to the extent of the amount of the total allotment made under such section for the entity;

(2) only to the extent of the Federal payments corresponding to the amount of non-Federal contributions made by the entity under section 7303;

(3) only if section 7301(a)(4) has not terminated the standard allotment for the entity; and

(4) only if subsection (d) has not terminated the availability of the contract amounts provided from the total allotment.

(d) AVAILABILITY OF CONTRACT AMOUNTS.—With respect to the 24-month period beginning on the date on which contract amounts under section 7301 for a fiscal year become available to an eligible public entity, any portion of such amounts that is not obligated by the entity before the expiration of such period shall lapse into the Account and be available for contracts under such subsection for the following fiscal year.

SEC. 7303. REQUIREMENT OF MATCHING FUNDS.

(a) IN GENERAL.—The Secretary may not award a contract under section 7301 for a fiscal year to an eligible public entity unless the public entity agrees, with respect to the costs of the program to be carried out in such year by the entity pursuant to such section, to make available (directly or through donations from public or private entities) non-Federal contributions toward such costs in an amount that is not less than 10 percent of such costs.

(b) DETERMINATION OF AMOUNT OF NON-FEDERAL CONTRIBUTION.—Non-Federal contributions required in subsection (a) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

SEC. 7304. USE OF CONTRACT AMOUNTS.

(a) IN GENERAL.—Contract amounts under section 7301 may be used—

(1) to perform risk assessments and inspections in eligible facilities;

(2) to provide for the abatement of lead-based paint hazards in eligible facilities;

(3) to provide for the additional cost of abatement of lead-based paint hazards in eligible facilities undergoing renovation funded by other sources;

(4) with respect to common areas in residential structures containing eligible residential units and dwelling units that are not eligible residential units, to perform risk assessments and inspections, to provide for the abatement of lead-based paint hazards, and to provide for the additional cost of abatement of lead-based paint hazards in such structures undergoing renovation funded by sources other than this subtitle; except that the ratio of the contract amounts used with respect to a structure for purposes under this paragraph to the total cost of the risk assessments, inspections, and abatement for common areas of the structure may not exceed the ratio of the number of eligible residential units in the structure to the number of dwelling units in the structure that are not eligible residential units;

(5) to ensure that risk assessments, inspections, and abatements are carried out by certified contractors in accordance with section 402 of the Toxic Substances Control Act;

(6) to monitor the blood-lead levels of workers involved in lead hazard abatement activities funded with contract amounts;

(7) to test soil, interior surface dust, and the blood-lead levels of children who are less than 6 years of age residing in eligible residential units after lead-based paint hazard abatement activity has been conducted, to assure that such activity does not cause excessive exposures to lead;

(8) to train employees and nonprofit contractors of eligible public entities conducting activities funded with contract amounts to conduct such activities, except that such training shall be provided through training providers accredited under sections 402 and 404 of the Toxic Substances Control Act;

(9) to assist in the temporary relocation of occupants of eligible residential units while lead hazard abatement activities are being conducted for such units;

(10) to acquire, renovate, and maintain temporary housing for low-income occupants of eligible residential units while lead hazard abatement activities are being conducted for such units;

(11) to undertake emergency measures;

(12) only if expressly authorized by regulations issued by the Secretary—

(A) to perform risk assessment, inspection, and abatement activities in dwelling units that are not eligible residential units but are undergoing renovation pursuant to which they will be made available for occupancy subject to provisions of section 7306 that apply to eligible residential units;

(B) to assist in the permanent relocation of families with children who are less than 6 years of age and have elevated blood levels; or

(C) to conduct activities to prevent degradation of lead-based paint, including activities to control moisture; and

(13) to carry out such other activities that the Secretary determines, by regulation, are appropriate to promote the purposes of this subtitle.

(b) FORMS OF ASSISTANCE.—

(1) **IN GENERAL.**—Subject to paragraph (2), contract amounts under section 7301 may be used to carry out activities under subsection (a) through a variety of programs, including direct provision of such services, grants, loans, equity investments, revolving loan funds, loan funds, loan guarantees, interest write-downs, and other forms of assistance approved by the Secretary.

(2) **REQUIREMENTS FOR GRANTS BY STATES TO UNITS OF GENERAL LOCAL GOVERNMENT.**—A State may not provide a grant to any public entity or other unit of general local government using contract amounts under section 7301 unless such entity or unit has a local lead-based paint law in effect for its entire jurisdiction. This paragraph may not be construed to limit the use of contract amounts under section 7301 to provide assistance in any form authorized under paragraph (1) other than such grants.

SEC. 7305. REQUIREMENTS OF ELIGIBLE PUBLIC ENTITIES.

(a) **COMPLIANCE WITH PLAN.**—Contract amounts may be expended by the eligible public entity receiving the contract only in accordance with the plan for the entity approved by the Secretary under section 7307.

(b) **CERTIFICATION OF PERSONNEL AND COMPLIANCE.**—Contract amounts may not be expended for risk-assessment, inspection, or abatement activities unless the eligible public entity ensures that the individuals conducting such activities have been certified in accordance with the requirements of section 402 of the Toxic Substances Control Act.

(c) **LIMITATION OF ADMINISTRATIVE EXPENSES.**—Not more than 10 percent of a contract amounts under section 7301 may be used for administrative expenses associated with the activities under section 7304(a).

(d) **LIMITATION ON EMERGENCY MEASURES.**—Not more than 20 percent of a contract amounts under section 7301 may be used to undertake emergency measures.

(e) **PROHIBITION OF SUBSTITUTION OF FUNDS.**—Contract amounts may not be used to replace other amounts made available or designated by State or local governments for use for the purposes under section 7304(a).

(f) **FINANCIAL RECORDS.**—An eligible public entity that receives a contract under section 7301 shall maintain any financial records that the Secretary shall require to ensure proper accounting and disbursing of contract amounts, and shall provide such records to the Secretary upon request.

(g) **USE OF AMOUNTS TO ASSIST SMALL BUSINESSES.**—Notwithstanding section 7304, not more than 1 percent of amounts under a contract under section 7301 may be used to provide assistance or incentives to nonprofit organizations and small businesses, which have 10 or fewer employees (or such other number of employees as the Secretary provides by regulation), to encourage such organizations and businesses to obtain or engage in work involving performing risk assessments and inspections, conducting lead hazard abatement activities, or conducting emergency measures and to assist such businesses or organizations to obtain such work.

SEC. 7306. CONTINUED USE OF ELIGIBLE RESIDENTIAL UNITS AS AFFORDABLE HOUSING.

(a) **AFFORDABLE HOUSING REQUIREMENT.**—For the duration of the period described in subsection (b), any eligible residential unit for which abatement activities are carried out with contract amounts shall—

(1) in the case of a rental dwelling unit—

(A) bear a rent (not including any utility charges) that does not exceed the fair market rental established under section 8 of the United States Housing Act of 1937 and applicable to a unit in the area of comparable size and type; and

(B) not be refused for leasing to a holder of a voucher or certificate of eligibility under section 8 of the United States Housing Act of 1937 because of the status of the prospective tenant as a holder of such voucher or certificate of eligibility; or

(2) in the case of a unit that is occupied by the owner of the unit or for which the family that will occupy the unit has entered into a contract to purchase the unit, be occupied by a family—

(A) whose members include (I) a child who is less than 6 years of age, or (II) a pregnant female; and

(B) that is a low-income family.

(b) **APPLICABLE PERIOD.**—For any eligible residential unit involved, the period referred to in subsection (a) is the period beginning upon the date that post-abatement clearance testing is satisfactorily completed and consisting of a number of consecutive months equal to the quotient resulting from dividing by 85.0 the amount of contract amounts expended for the unit.

(c) **AGREEMENT AND LIEN.**—

(1) **AGREEMENT.**—Contract amounts may be expended for abatement activities for an eligible residential unit only if, before the commencement of the activities, the eligible public entity receiving the contract has made reasonable efforts to enter into an agreement with the owner of the unit that—

(A) provides for the abatement activities to be carried out;

(B) establishes a lien under paragraph (3) on the unit to secure compliance with subsection (a); and

(C) provides penalties for the breach of the agreement, as the Secretary determines appropriate.

(2) **NONCONSENSUAL LIEN.**—In any case in which the eligible public entity involved is unable to enter into an agreement under paragraph (1) with the owner of any eligible residential unit, the expenditure of any contract amounts for abatement activities for the unit shall create a lien under paragraph (3).

(3) **TERMS OF LIEN.**—A lien under this paragraph shall be in the amount of the expenditures made with contract amounts for abatement activities carried out with respect to the unit, with the eligible public entity as the holder of the lien.

(d) **RECOVERY OF CONTRACT AMOUNTS.**—

(1) **AUTHORITY.**—If, at any time during the period described in subsection (b), an eligible residential unit for which contract amounts were expended for abatement activities does not comply with the requirements under subsection (a), the eligible public entity or the Secretary may recover from the owner of the struc-

ture all or part of the expenditures of the contract made for abatement activities conducted with respect to the unit, together with interest on such amounts. Such interest shall be calculated from the date of initial noncompliance with the requirements under subsection (a) at a rate equal to the coupon issue yield equivalent (as determined by the Secretary of the Treasury) of the average accepted auction price for the last auction of 52-week United States Treasury bills settled immediately prior to the date of the recovery.

(2) CAUSE OF ACTION.—An eligible public entity or the Secretary may bring an action in any court of competent jurisdiction to collect contract amounts and interest under this section.

(3) AWARD OF COSTS.—In any action brought by an eligible entity or the Secretary to recover such amounts, if the entity or Secretary prevails or substantially prevails in such action, the court shall award the costs of litigation (including reasonable attorneys and expert witness fees) if the court determines such an award is appropriate.

(4) USE OF RECOVERED AMOUNTS.—Any amounts recovered by an eligible public entity pursuant to this subsection shall be treated as amounts provided to the entity in a contract under section 7301 and shall be subject to the provisions of this subtitle applicable to such contract amounts. Any amounts recovered by the Secretary pursuant to this subsection shall be made available and used in accordance with section 7313.

SEC. 7307. PLAN REGARDING ACTIVITIES OF CONTRACTOR.

(a) REQUIREMENTS.—With respect to a contract under section 7301 for a public entity for a fiscal year, a plan is in accordance with this section only if the following requirements are met:

(1) SUBMISSION.—The public entity submits a plan to the Secretary not later than May 1st of the preceding fiscal year (or such other date as the Secretary may establish for submission of plans for fiscal year 1995) containing the information required under this subsection.

(2) PRIORITIES FOR USE OF CONTRACTS.—The plan provides, to the extent practicable, that—

(A) in expending contract amounts, the ratio of the amount expended for performing risk assessments, inspections, and abatement activities for eligible residential units in rental housing to the amount expended for such assessments, inspections, and activities for eligible residential units that are owner-occupied shall be not less than 2 times the quotient of—

(i) the number of rental housing units in the jurisdiction of the public entity whose construction was completed by not later than January 1, 1950; divided by

(ii) the number of owner-occupied housing units in the jurisdiction whose construction was completed by not later than January 1, 1950; and

(B) in expending contract amounts for activities for eligible residential units that are owner-occupied, priority shall be given—

(i) first, for units occupied by families (I) whose members include a child who is less than 6 years of age or a pregnant woman, and (II) whose family income does not exceed the official poverty line (as defined by the Office of Management and Budget and revised periodically in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to the family of the size involved;

(ii) second, for units occupied by families (I) whose members include a child who is less than 6 years of age or a pregnant woman, and (II) that are very-low income families;

(iii) third, for units occupied by families (I) whose members include a child who is less than 6 years of age or a pregnant woman, and (II) that are low-income families; and

(iv) fourth, for units occupied by other families whose members include (I) a child who is less than 6 years of age, or (II) a pregnant woman.

(3) AVAILABILITY OF RENTAL UNITS.—The plan provides that the eligible public entity shall encourage owners of eligible residential units for which risk assessments, inspections, or abatement activities have been conducted using contract amounts and that are made available for rental to make such units available to families whose members include (A) a child who is less than 6 years of age, or (B) a pregnant woman.

(4) PROGRAM STRATEGY.—The plan contains descriptions of the methods by which the public entity—

(A) will provide priority for the use of contract amounts in accordance with paragraph (2);

(B) will encourage owners of units referred to in paragraph (3) to make such units available to families described in such paragraph;

(C) will select the eligible facilities for which risk assessments are to be conducted using contract amounts;

(D) will select the eligible facilities for which abatement activities are to be conducted using contract amounts; and

(E) will ensure compliance with the requirements of subsections (a) through (c) of section 7306.

(5) DISTRIBUTION OF AMOUNTS BY STATES.—In the case of a public entity that is a State, the plan contains a description of the method by which the State will expend or distribute contract amounts to units of general local government in accordance with this subtitle and will ensure compliance with the provisions of this subtitle with respect to such distributed amounts.

(6) LOCAL LEAD-BASED PAINT LAWS.—The plan contains evidence there are in effect, for the entire jurisdiction of the public entity, local lead-based paint laws.

(7) COORDINATION WITH LOCAL AGENCIES.—The plan provides for the public entity to coordinate with State and local health, housing, and environmental agencies and contains a description of the methods by which the entity shall ensure that such coordination is carried out.

(8) EMPLOYMENT.—The plan provides for the public entity to make training and employment opportunities available in connection with activities carried out with contract amounts available to low-income residents of areas having substantial numbers of eligible facilities with lead-based paint hazards and to community-based contractors and nonprofit organizations serving such areas.

(9) CERTIFICATION OF PREVIOUS COMPLIANCE.—With respect to fiscal year 1996 and subsequent fiscal years, the plan contains a certification that, for the most recent fiscal year for which the entity received a contract under this subtitle, the entity complied with the requirements under sections 7305 and 7306.

(10) CITIZEN PARTICIPATION.—Before submitting the plan, the public entity has—

(A) made available to its citizens, public agencies, and other interested parties information concerning the amount the entity expects to receive under the contract and the proposed uses of the contract amounts;

(B) published a proposed plan in a manner that, in the determination of the Secretary, affords affected citizens, public agencies, and other interested parties a reasonable opportunity to examine its content and to submit comments on the proposed plan;

(C) held 1 or more public hearings to obtain the views of citizens, public agencies, and other interested parties on the needs of the public entity with respect to lead-based paint hazards in eligible facilities;

(D) provided citizens, public agencies, and other interested parties with reasonable access to records regarding the uses of amounts from any contracts the public entity has received under this subtitle during the preceding 5 years;

(E) considered any comments or views of citizens in preparing the final plan for submission under this section, and has attached a summary of such comments or views to the plan submitted; and

(F) made the plan submitted available to the public.

A public entity shall be considered to have complied with the requirements of this paragraph if the public entity submits a comprehensive housing affordability strategy required under section 105 of the Cranston-Gonzalez National Affordable Housing Act that includes the information required under paragraphs (1) through (9) of this section, and complies with the requirements of section 107 of such Act (relating to citizen participation).

(b) REVIEW.—

(1) IN GENERAL.—Upon the submission of a plan under this section, the Secretary shall review the plan to determine whether it is in accordance with this section. Not later than 90 days after receipt by the Secretary, the Secretary shall approve the plan unless the Secretary determines that it has not been submitted in accordance with this section, in which case the Secretary shall disapprove the plan.

(2) NOTIFICATION.—The Secretary shall immediately notify the public entity submitting a plan, in writing, of any approval or disapproval of the plan. A plan shall be considered to have been approved under this subsection for purposes of section 7301(b)(1) unless the Secretary provides notice under this paragraph of disapproval during the period referred to paragraph (1) of this subsection.

(3) **DISAPPROVAL.**—In the case of a plan disapproved by the Secretary, the Secretary shall include with the notification of disapproval a written description of the reasons for the disapproval identifying the specific deficiencies of the plan.

(4) **AMENDMENTS AND RESUBMISSION.**—Any public entity whose plan has been disapproved may amend or resubmit the plan during the 60-day period beginning upon notice of disapproval. The Secretary shall review, and approve or disapprove a plan amended or resubmitted under this paragraph not later than 60 days after receipt of the resubmitted plan, and shall immediately notify the public entity amending or resubmitting the plan, in writing, of such approval or disapproval. A plan resubmitted or amended under this paragraph shall be considered to have been approved under this subsection for purposes of section 7301(b)(1) unless the Secretary provides notice under this paragraph of disapproval during such period.

SEC. 7308. ANNUAL REPORTS TO SECRETARY.

(a) **IN GENERAL.**—An eligible public entity that receives a contract under section 7301 shall submit to the Secretary, for such fiscal year, a report under this section. The report shall be submitted not later than the expiration of the 6-month period beginning upon the termination of the fiscal year in which the contract is received, in the form and manner required by the Secretary.

(b) **CONTENTS.**—A report under this section shall include the following information:

(1) The sources and amounts from which the entity obtained the non-Federal contributions required by section 7303.

(2) The number of children within the jurisdiction of the eligible public entity who have been screened for blood-lead levels and the findings resulting from such screenings.

(3) The amount of funds provided under section 7301 that were expended for each of the categories of activities authorized under section 7304(a).

(4) The amount of funds provided under section 7301 that were expended for abatement activities with respect to owner-occupied dwelling units and the amount so expended with respect to rental dwelling units.

(5) The number of eligible facilities for which—

(A) evaluation activities were conducted;

(B) emergency measures were conducted (and a description of such activities);

(C) abatement activities were commenced;

(D) abatement activities were completed and the facility passed post-abatement clearance testing; and

(E) abatement activities were completed and the facility failed to pass post-abatement clearance testing.

(6) With respect to eligible facilities described in paragraph (5)(E), a description of the status of such facilities and the reasons underlying such status.

(7) For each eligible facility for which abatement activities and emergency measures have been conducted using contract amounts, the address and owner of the facility and the census tracts within which the facility is located.

SEC. 7309. DETERMINATION OF AMOUNT OF ALLOTMENT.

(a) **AMOUNT OF TOTAL ALLOTMENT.**—The amount of a total allotment under section 7301(a)(2) for an eligible public entity for a fiscal year shall be an amount equal to the sum of—

(1) the amount of the standard allotment determined for the entity under subsection (b); and

(2) the amount of the supplemental allotment determined for the entity under subsection (d).

(b) **AMOUNT OF STANDARD ALLOTMENT.**—The amount of a standard allotment for an eligible public entity for a fiscal year shall be the product of—

(1) the amount in the Account that under section 7302(a) is available for allotments for the fiscal year; and

(2) a percentage equal to the mean of the 3 percentages determined under subsection (c) with respect to the entity.

(c) **PERCENTAGES REGARDING RELEVANT FACTORS.**—Subject to subsection (e), the 3 percentages referred to in subsection (b)(2) with respect to an eligible public entity are as follows:

(1) **CHILDREN IN POVERTY.**—The percentage equal to the quotient of—

(A) an amount equal to the number of children who are less than 6 years of age residing in the jurisdiction of the entity whose families have incomes equal to or below the official poverty line (as defined by the Office of Man-

agement and Budget and revised periodically in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to the family of the size involved; divided by

(B) an amount equal to the sum of the respective amounts determined under subparagraph (A) for each eligible public entity.

(2) FAMILIES IN PRE-1950 HOUSING.—The percentage equal to the quotient of—
(A) an amount equal to the number of families residing in the jurisdiction of the entity that—

(i) have incomes equal to or less than such poverty line; and

(ii) reside in residential units whose construction was completed by not later than January 1, 1950; divided by

(B) an amount equal to the sum of the respective amounts determined under subparagraph (A) for each eligible public entity.

(3) FAMILIES IN PRE-1960 HOUSING.—The percentage equal to the quotient of—
(A) an amount equal to the number of families residing in the jurisdiction of the entity that—

(i) have incomes equal to or less than such poverty line; and

(ii) reside in residential units whose construction was completed by not later than January 1, 1960; divided by

(B) an amount equal to the sum of the respective amounts determined under subparagraph (A) for each eligible public entity.

(d) AMOUNT OF SUPPLEMENTAL ALLOTMENT.—

(1) IN GENERAL.—The amount of a supplemental allotment for an eligible public entity for a fiscal year shall be the product of—

(A) an amount equal to the aggregate amount of any standard allotments for the fiscal year under section 7301(a)(1) terminated under section 7301(a)(4); and

(B) a percentage equal to the mean of the 3 percentages determined under paragraph (2) with respect to the entity.

(2) PERCENTAGES REGARDING RELEVANT FACTORS.—Subject to subsection (e), the 3 percentages referred to in paragraph (1)(B) with respect to an eligible public entity are as follows:

(A) CHILDREN IN POVERTY.—The percentage equal to the quotient of—

(i) the amount determined under subsection (c)(1)(A) for the entity; divided by

(ii) an amount equal to the sum of the respective amounts determined under subsection (c)(1)(A) for each eligible public entity that receives a contract under section 7301.

(B) FAMILIES IN PRE-1950 HOUSING.—The percentage equal to the quotient of—

(i) the amount determined under subsection (c)(2)(A) for the entity; divided by

(ii) an amount equal to the sum of the respective amounts determined under subsection (c)(2)(A) for each eligible public entity that receives a contract under section 7301.

(C) FAMILIES IN PRE-1960 HOUSING.—The percentage equal to the quotient of—

(i) the amount determined under subsection (c)(3)(A) for the entity; divided by

(ii) an amount equal to the sum of the respective amounts determined under subsection (c)(3)(A) for each eligible public entity that receives a contract under section 7301.

(e) PROHIBITION AGAINST DUPLICATIVE COUNTING.—In the case of any eligible public entity within whose jurisdiction there exists the jurisdiction of another eligible public entity, the calculations regarding percentages made under each of paragraphs (1) through (3) of subsection (c) and under each of subparagraphs (A) through (C) of subsection (d)(2) may not include any numbers representing children or families (as the case may be) who reside in the jurisdiction of the other eligible public entity.

SEC. 7310. EVALUATION OF PROGRAM; REPORTS TO CONGRESS.

(a) EVALUATIONS.—The Secretary shall, directly or through contracts with public or private entities, carry out evaluations of representative programs carried out by eligible public entities pursuant to this subtitle.

(b) REPORTS.—Not later than the expiration of the 18-month period beginning on the date of the enactment of this Act, and every 24 months thereafter, the Secretary shall submit to the Congress a report—

(1) summarizing evaluations carried out pursuant to subsection (a) during the preceding 2 fiscal years; and

(2) summarizing reports submitted to the Secretary pursuant to section 7308.

SEC. 7311. USE OF ACCOUNT AMOUNTS FOR EVALUATION AND ADMINISTRATION.

In each year, of any amounts in the Account on October 1, the Secretary may reserve not more than 0.1 percent for costs relating to carry out this subtitle (including carrying out evaluations under section 7310) during the fiscal year beginning on such October 1.

SEC. 7312. DEFINITIONS.

For purposes of this subtitle:

(1) The term "Account" means the Lead Abatement Program Account established under section 9512 of the Internal Revenue Code of 1986.

(2) The term "child day-care structure" means a structure—

(A) whose purpose includes provision of child care to children under the age of 7; and

(B) that is operated by an entity licensed by a State or political subdivision of a State to engage in such business.

The term includes rooms and common areas in school buildings used for activities described in subparagraph (A).

(3) The term "city" has the meaning given such term in section 102 of the Housing and Community Development Act of 1974.

(4) The term "contract amounts" means amounts received under a contract under this subtitle.

(5) The term "eligible public entity" has the meaning given such term in section 7301(b).

(6) The term "eligible residential unit" means an eligible facility under paragraph (5)(A).

(7) The term "eligible facility" means—

(A) a dwelling unit in target housing that—

(i) complies with the requirements of section 7306(a); and

(ii) is not federally owned housing, federally assisted housing, or public housing; or

(B) a child day-care structure constructed prior to 1978.

(8) The term "emergency measures" means measures to correct identified exposure hazards posed by deteriorated paint, lead-contaminated dust, or lead-contaminated soil at eligible residential units occupied by families whose members include (A) a child who is less than 6 years of age, or (B) a pregnant female.

(9) The term "local lead-based paint law" means any law, ordinance, or code that expressly provides protection of individuals from hazards posed by lead-based paint in dwelling units.

(10) The terms "low-income family" and "very low-income family" have the meanings given such terms in section 104 of the Cranston-Gonzalez National Affordable Housing Act.

(11) The term "post-abatement clearance testing" means testing required before occupancy of an abated unit in accordance with regulations implementing title IV of the Toxic Substances Control Act.

(12) The term "public entity" means a State, urban county, or city.

(13) The term "standard allotment" means the allotment made for eligible public entities under section 7301(a)(1).

(14) The term "State" means each of the several States, the District of Columbia, and each of the Commonwealth of Puerto Rico, American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, the Virgin Islands, and the Trust Territory of the Pacific Islands.

(15) The term "supplemental allotment" means the portion of a total allotment in the amount determined in accordance with section 7309(d).

(16) The term "total allotment" means the allotment made under section 7301(a)(2).

(17) The term "urban county" has the meaning given such term in section 102 of the Housing and Community Development Act of 1974, except that in determining whether 200,000 or more individuals reside in the county, the population of any metropolitan cities (as defined in such section) in the county shall be included.

SEC. 7313. REGULATIONS.

(a) **IN GENERAL.**—The Secretary shall issue any regulations necessary to carry out this subtitle. Such regulations shall include regulations regarding the content and submission of plans under section 7307.

(b) **REQUIREMENTS.**—The Secretary shall issue the regulations required in subsection (a) through rulemaking in accordance with the procedures established under section 553 of title 5, United States Code, regarding substantive rules. Such regulations shall be issued not later than the expiration of the 12-month period beginning on the date of the enactment of this Act.

(c) **RULE OF CONSTRUCTION.**—Any failure by the Secretary to issue any regulations required under this section shall not affect the effectiveness of the provisions of this subtitle.

Subtitle E—Federal Grants for Managed Care Plans

SEC. 7401. FEDERAL GRANTS FOR MANAGED CARE PLANS.

(a) **PROMOTING ESTABLISHMENT OF MANAGED CARE PLANS IN UNDERSERVED AREAS.**—The Secretary of Health and Human Services shall make grants to eligible public and nonprofit private organizations—

(1) for the development and initial operation of staff or group model health maintenance organizations in areas designated by the Secretary as health professional shortage areas under section 332 of the Public Health Service Act; and

(2) for the development of other managed care delivery programs in rural areas designated by the Secretary as such health professional shortage areas.

(b) **ELIGIBILITY OF ORGANIZATIONS.**—A public or nonprofit private organization is eligible to receive a grant under this subtitle if the organization submits an application to the Secretary (in such form and manner as the Secretary may require) containing—

(1) assurances that the applicant organization has conducted sufficient planning for the successful operation of a health maintenance organization or rural managed care plan;

(2) information demonstrating that the establishment and operation of the health maintenance organization or rural managed care plan by the applicant is feasible; and

(3) such other information and assurances as the Secretary may require.

(c) **PERIOD OF GRANT.**—The Secretary shall provide funds under a grant awarded under this subtitle over a 1-year period, except that (upon application of the recipient and approval by the Secretary) the Secretary may renew a grant awarded under this part for not more than 2 additional 1-year periods.

(d) **DEFINITIONS.**—

(1) **HEALTH MAINTENANCE ORGANIZATION.**—

(A) **HEALTH MAINTENANCE ORGANIZATION.**—The term “health maintenance organization” means an eligible organization with a contract under section 1876 or a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act).

(B) **STAFF OR GROUP MODEL HEALTH MAINTENANCE ORGANIZATION.**—The term “staff or group model health maintenance organization” means a health maintenance organization (as defined in paragraph (1)) that furnishes substantially all of its primary care health services at its own facilities through health care professionals who do not provide substantial health care services other than on behalf of such organization.

(2) **RURAL AREA.**—The term “rural area” has the meaning given such term in section 1886(d)(2)(D) of the Social Security Act.

SEC. 7402. USE OF FUNDS.

An organization awarded a grant under this subtitle may use the funds provided under the grant for the following purposes:

(1) Conducting market surveys.

(2) Conducting activities related to the initial enrollment of individuals.

(3) Raising working capital during the startup period.

(4) Recruiting physicians and other health personnel.

(5) Acquiring buildings and equipment.

(6) Developing provider networks.

(7) Such other purposes as the Secretary may specify.

SEC. 7403. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated for grants under this subtitle \$35,000,000 for each of the fiscal years 1995 through 1999.

Subtitle F—Emergency Medical Services in Rural Areas

SEC. 7501. ESTABLISHMENT OF FEDERAL OFFICE OF RURAL EMERGENCY MEDICAL SERVICES.

(a) **IN GENERAL.**—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall establish an office to be known as the Office of Rural Emergency Medical Services, which shall be headed by a director appointed by the Secretary. The Secretary shall carry out this title acting through the Director of such Office.

(b) **GENERAL AUTHORITIES AND DUTIES.**—With respect to rural emergency medical services, the Secretary shall—

(1) conduct and support research, training, evaluations, and demonstration projects;

(2) foster the development of appropriate, modern systems of such services through the sharing of information among agencies and individuals involved in the study and provision of such services;

(3) foster the development of regional systems for the provision of such services;

(4) sponsor workshops and conferences;

(5) as appropriate, disseminate to public and private entities information obtained in carrying out paragraphs (1) through (4);

(6) provide technical assistance to State and local agencies;

(7) coordinate activities of the Department of Health and Human Services; and

(8) as appropriate, coordinate activities of such Department with activities of other Federal agencies.

(c) **CERTAIN REQUIREMENTS.**—With respect to rural emergency medical services, the Secretary shall ensure that activities under subsection (b) are carried out regarding—

(1) maintaining an adequate number of health professionals with expertise in the provision of the services;

(2) developing, periodically reviewing, and revising as appropriate, in collaboration with appropriate public and private entities, guidelines for the provision of such services; and

(3) the appropriate use of available technologies, including communications technologies.

(d) **GRANTS, COOPERATIVE AGREEMENTS, AND CONTRACTS.**—In carrying out subsections (b) and (c), the Secretary may make grants and enter into cooperative agreements and contracts.

SEC. 7502. SUPPORT FOR STATE OFFICES OF RURAL EMERGENCY MEDICAL SERVICES.

(a) **PROGRAM OF GRANTS.**—The Secretary of Health and Human Services may make grants to States for the purpose of improving the availability and quality of rural emergency medical services through the operation of State offices of rural emergency medical services. A grant made under this section shall be provided over a 3-year period.

(b) **REQUIREMENT OF MATCHING FUNDS.**—

(1) **IN GENERAL.**—The Secretary may not make a grant under subsection (a) unless the State involved agrees, with respect to the costs to be incurred by the State in carrying out the purpose described in such subsection, to provide non-Federal contributions toward such costs in an amount that—

(A) for the first fiscal year of payments under the grant, is not less than \$1 for each \$3 of Federal funds provided in the grant;

(B) for any second fiscal year of such payments, is not less than \$1 for each \$1 of Federal funds provided in the grant; and

(C) for any third fiscal year of such payments, is not less than \$3 for each \$1 of Federal funds provided in the grant.

(2) **DETERMINATION OF AMOUNT OF NON-FEDERAL CONTRIBUTION.**—

(A) Subject to subparagraph (B), non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or

services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

(B) The Secretary may not make a grant under subsection (a) unless the State involved agrees that—

(i) for the first fiscal year of payments under the grant, 100 percent or less of the non-Federal contributions required in paragraph (1) will be provided in the form of in-kind contributions;

(ii) for any second fiscal year of such payments, not more than 50 percent of such non-Federal contributions will be provided in the form of in-kind contributions; and

(iii) for any third fiscal year of such payments, such non-Federal contributions will be provided solely in the form of cash.

(c) CERTAIN REQUIRED ACTIVITIES.—The Secretary may not make a grant under subsection (a) unless the State involved agrees that activities carried out by an office operated pursuant to such subsection will include—

(1) coordinating the activities carried out in the State that relate to rural emergency medical services;

(2) activities regarding the matters described in paragraphs (1) through (4) section 7501(b);

(3) identifying Federal and State programs regarding rural emergency medical services and providing technical assistance to public and nonprofit private entities regarding participation in such programs.

(d) REQUIREMENT REGARDING ANNUAL BUDGET FOR OFFICE.—The Secretary may not make a grant under subsection (a) unless the State involved agrees that, for any fiscal year for which the State receives such a grant, the office operated pursuant to subsection (a) will be provided with an annual budget of not less than \$50,000.

(e) CERTAIN USES OF FUNDS.—

(1) RESTRICTIONS.—The Secretary may not make a grant under subsection (a) unless the State involved agrees that—

(A) if research with respect to rural emergency medical services is conducted pursuant to the grant, not more than 10 percent of the grant will be expended for such research; and

(B) the grant will not be expended to provide rural emergency medical services (including providing cash payments regarding such services).

(2) ESTABLISHMENT OF OFFICE.—Activities for which a State may expend a grant under subsection (a) include paying the costs of establishing an office of rural emergency medical services for purposes of such subsection.

(f) REPORTS.—The Secretary may not make a grant under subsection (a) unless the State involved agrees to submit to the Secretary reports containing such information as the Secretary may require regarding activities carried out under this section by the State.

(g) REQUIREMENT OF APPLICATION.—The Secretary may not make a grant under subsection (a) unless an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for grants under this section not more than \$3,000,000 for each fiscal year beginning with fiscal year 1996.

SEC. 7503. GRANTS TO STATES REGARDING AIRCRAFT FOR TRANSPORTING RURAL VICTIMS OF MEDICAL EMERGENCIES.

(a) IN GENERAL.—The Secretary of Health and Human Services (hereafter referred to as the “Secretary”) shall make grants to States to assist such States in the creation or enhancement of air medical transport systems that provide victims of medical emergencies in rural areas with access to treatments for the injuries or other conditions resulting from such emergencies.

(b) APPLICATION AND PLAN.—

(1) APPLICATION.—To be eligible to receive a grant under subsection (a), a State shall prepare and submit to the Secretary an application in such form, made in such manner, and containing such agreements, assurances, and information, including a State plan as required in paragraph (2), as the Secretary determines to be necessary to carry out this section.

(2) STATE PLAN.—An application submitted under paragraph (1) shall contain a State plan that shall—

(A) describe the intended uses of the grant proceeds and the geographic areas to be served;

(B) demonstrates that the geographic areas to be served, as described under subparagraph (A), are rural in nature;

(C) demonstrate that there is a lack of facilities available and equipped to deliver advanced levels of medical care in the geographic areas to be served;

(D) demonstrate that in utilizing the grant proceeds for the establishment or enhancement of air medical services the State would be making a cost-effective improvement to existing ground-based or air emergency medical service systems;

(E) demonstrate that the State will not utilize the grant proceeds to duplicate the capabilities of existing air medical systems that are effectively meeting the emergency medical needs of the populations they serve;

(F) demonstrate that in utilizing the grant proceeds the State is likely to achieve a reduction in the morbidity and mortality rates of the areas to be served, as determined by the Secretary;

(G) demonstrate that the State, in utilizing the grant proceeds, will—

(i) maintain the expenditures of the State for air and ground medical transport systems at a level equal to not less than the level of such expenditures maintained by the State for the fiscal year preceding the fiscal year for which the grant is received; and

(ii) ensure that recipients of direct financial assistance from the State under such grant will maintain expenditures of such recipients for such systems at a level at least equal to the level of such expenditures maintained by such recipients for the fiscal year preceding the fiscal year for which the financial assistance is received;

(H) demonstrate that persons experienced in the field of air medical service delivery were consulted in the preparation of the State plan;

(I) contain such other information as the Secretary may determine appropriate.

(c) CONSIDERATIONS IN AWARDING GRANTS.—In determining whether to award a grant to a State under this section, the Secretary shall—

(1) consider the rural nature of the areas to be served with the grant proceeds and the services to be provided with such proceeds, as identified in the State plan submitted under subsection (b); and

(2) give preference to States with State plans that demonstrate an effective integration of the proposed air medical transport systems into a comprehensive network or plan for regional or statewide emergency medical service delivery.

(d) STATE ADMINISTRATION AND USE OF GRANT.—

(1) IN GENERAL.—The Secretary may not make a grant to a State under subsection (a) unless the State agrees that such grant will be administered by the State agency with principal responsibility for carrying out programs regarding the provision of medical services to victims of medical emergencies or trauma.

(2) PERMITTED USES.—A State may use amounts received under a grant awarded under this section to award subgrants to public and private entities operating within the State.

(3) OPPORTUNITY FOR PUBLIC COMMENT.—The Secretary may not make a grant to a State under subsection (a) unless that State agrees that, in developing and carrying out the State plan under subsection (b)(2), the State will provide public notice with respect to the plan (including any revisions thereto) and facilitate comments from interested persons.

(e) NUMBER OF GRANTS.—The Secretary shall award grants under this section to not less than 7 States.

(f) REPORTS.—

(1) REQUIREMENT.—A State that receives a grant under this section shall annually (during each year in which the grant proceeds are used) prepare and submit to the Secretary a report that shall contain—

(A) a description of the manner in which the grant proceeds were utilized;

(B) a description of the effectiveness of the air medical transport programs assisted with grant proceeds; and

(C) such other information as the Secretary may require.

(2) TERMINATION OF FUNDING.—In reviewing reports submitted under paragraph (1), if the Secretary determines that a State is not using amounts provided under a grant awarded under this section in accordance with the State plan submitted by the State under subsection (b), the Secretary may terminate the payment of amounts under such grant to the State until such time as the Secretary determines that the State comes into compliance with such plan.

(g) DEFINITION.—As used in this section, the term “rural areas” has the meaning given such term in section 1886(d)(2)(D) of the Social Security Act.

(h) **AUTHORIZATION OF APPROPRIATIONS.**—There are authorized to be appropriated to make grants under this section, \$15,000,000 for fiscal year 1996, and such sums as may be necessary for each of the fiscal years 1997 through 2000.

Subtitle G—Biomedical Research Program Account

SEC. 7601. BIOMEDICAL RESEARCH PROGRAMS.

(a) **IN GENERAL.**—From amounts in the Biomedical Research Program Account (established under section 9512 of the Internal Revenue Code of 1986), the Secretary shall conduct a program for the support of biomedical research.

(b) **SUPPORT OF CERTAIN ENTITIES.**—Awards of grants, cooperative agreements, and contracts may be made under subsection (a) to entities with appropriate expertise in biomedical research, including schools of medicine and osteopathic medicine, academic health centers, and entities that are eligible to receive awards from the National Institutes of Health.

(c) **PRIORITIES.**—The Secretary shall establish priorities for the conduct and support of projects of biomedical research under subsection (a).

Subtitle H—United States-Mexico Border Health Commission

SEC. 7701. AGREEMENT TO ESTABLISH BINATIONAL COMMISSION.

The President is authorized and encouraged to conclude an agreement with Mexico to establish a binational commission to be known as the United States-Mexico Border Health Commission.

SEC. 7702. DUTIES.

It should be the duty of the Commission—

(1) to conduct a comprehensive needs assessment in the United States-Mexico border area for the purposes of identifying, evaluating, preventing, and resolving health problems that affect the general population of the area;

(2) to implement the actions recommended by the needs assessment by—

(A) assisting in the coordination of the efforts of public and private persons to prevent and resolve such health problems,

(B) assisting in the coordination of the efforts of public and private persons to educate such population concerning such health problems, and

(C) developing and implementing programs to prevent and resolve such health problems and to educate such population concerning such health problems where a program is necessary to meet a need that is not being met by the efforts of other public or private persons; and

(3) to formulate recommendations to the Governments of the United States and Mexico concerning a fair and reasonable method by which the government of one country would reimburse a public or private person in the other country for the cost of a health care service that the person furnishes to a citizen or resident alien of the first country who is unable, through insurance or otherwise, to pay for the service.

SEC. 7703. OTHER AUTHORIZED FUNCTIONS.

In addition to the duties described in section 7702, the Commission should be authorized to perform the following additional functions as the Commission determines to be appropriate:

(1) To conduct or sponsor investigations, research, or studies designed to identify, study, and monitor health problems that affect the general population in the United States-Mexico border area.

(2) To provide financial, technical, or administrative assistance to public or private persons who act to prevent, resolve, or educate such population concerning such health problems.

SEC. 7704. MEMBERSHIP.

(a) **NUMBER AND APPOINTMENT OF UNITED STATES SECTION.**—The United States section of the Commission should be composed of 13 members. The section should consist of the following members:

(1) The Secretary of Health and Human Services or such individual's delegate.

(2) The commissioners of health from the States of Texas, New Mexico, California, and Arizona or such individuals' delegates.

(3) 2 individuals from each of the States of Texas, New Mexico, California, and Arizona who are nominated by the chief executive officer of one of such States and are appointed by the President from among individuals—

(A) who have a demonstrated interest in health issues of the United States-Mexico border area; and

(B) whose name appears on a list of 6 nominees submitted to the President by the chief executive officer of the State where the nominee resides.

(b) COMMISSIONER.—The Commissioner of the United States section of the Commission should be the Secretary of Health and Human Services or such individual's delegate to the Commission. The Commissioner should be the leader of the section.

SEC. 7705. REGIONAL OFFICES.

The Commission should establish no fewer than 2 regional border offices in locations selected by the Commission.

SEC. 7706. REPORTS.

Not later than February 1 of each year that occurs more than 1 year after the date of the establishment of the Commission, the Commission should submit an annual report to both the United States Government and the Government of Mexico regarding all activities of the Commission during the preceding calendar year.

SEC. 7707. DEFINITIONS.

For purposes of this subtitle:

(1) COMMISSION.—The term "Commission" means the United States-Mexico Border Health Commission authorized in section 7701.

(2) HEALTH PROBLEM.—The term "health problem" means a disease or medical ailment or an environmental condition that poses the risk of disease or medical ailment. The term includes diseases, ailments, or risks of disease or ailment caused by or related to environmental factors, control of animals and rabies, control of insect and rodent vectors, disposal of solid and hazardous waste, and control and monitoring of air and water quality.

(3) RESIDENT ALIEN.—The term "resident alien", when used in reference to a country, means an alien lawfully admitted for permanent residence to the country or otherwise permanently residing in the country under color of law (including residence as an asylee, refugee, or parolee).

(4) UNITED STATES-MEXICO BORDER AREA.—The term "United States-Mexico border area" means the area located in the United States and Mexico within 100 kilometers of the border between the United States and Mexico.

TITLE VIII—MEDICARE AND MEDICAID

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SEC. 8000. REFERENCES IN TITLE.

(a) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this title an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(b) REFERENCES TO OBRA.—In this title, the terms "OBRA-1986", "OBRA-1987", "OBRA-1989", "OBRA-1990", and "OBRA-1993" refer to the Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509), the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203), the Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239), the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-

508), and the Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66), respectively.

Subtitle A—Medicare Part C Program

SEC. 8001. ESTABLISHMENT OF MEDICARE PART C PROGRAM.

(a) IN GENERAL.—The Social Security Act is amended by adding after the titles added by sections 3001 and 5001 the following new title:

“TITLE XXIII—MEDICARE PART C; ASSISTANCE FOR LOW-INCOME INDIVIDUALS

“SEC. 2300. ESTABLISHMENT OF PROGRAMS.

“Not later than January 1, 1998, the Secretary shall establish and operate the following programs under this title:

“(1) A Medicare Part C Program under part A to provide coverage for the guaranteed national benefit package for eligible individuals who are not enrolled under a qualified health plan or entitled to benefits under part A of title XVIII.

“(2) A program of premium subsidies under subpart 1 of part B for certain low-income individuals covered under employer health program.

“(3) A program of supplemental benefits under subpart 2 of part B for certain low-income individuals.

“PART A—MEDICARE PART C PROGRAM

“Subpart 1—Eligibility and Enrollment

“SEC. 2301. ELIGIBILITY.

“(a) ELIGIBILITY TO ENROLL FOR HEALTH INSURANCE BENEFITS.—Each medicare part C eligible individual (as defined in subsection (b)) is eligible to enroll in the program under this part.

“(b) MEDICARE PART C ELIGIBLE INDIVIDUAL DEFINED.—In this part, subject to subsection (c), the term ‘medicare part C eligible individual’ means any eligible individual (as defined in section 1001(c) of the Health Security Act) who meets any of the following requirements:

“(1) CERTAIN PART-TIME, TEMPORARY, AND SEASONAL EMPLOYEES.—The individual is an employee described in section 3451(c)(1) of the Internal Revenue Code of 1986.

“(2) FULL-TIME EMPLOYEES OF ELECTING EMPLOYERS.—The individual is a full-time employee (as defined in section 3467(b)(1) of the Internal Revenue Code of 1986) of an employer that is not a large employer (within the meaning of section 3451(d) of such Code) and the employee is not a qualified employer-covered employee of the employer (as defined in section 3466(a) of such Code).

“(3) NON-WORKERS.—The individual is not an employee.

“(4) AFDC AND SSI RECIPIENTS.—The individual is an AFDC or SSI recipient.

“(5) EMPLOYED INDIVIDUALS WITH INCOME BELOW SPECIFIED PERCENTAGE OF INCOME THRESHOLD.—

“(A) IN GENERAL.—The individual—

“(i) is an employee of an employer that is not a large employer (within the meaning of section 3451(d) of the Internal Revenue Code of 1986), and

“(ii) is determined, under subpart 2 of part B in the manner described in section 2384, to have projected modified adjusted gross income that is less than the applicable percentage (specified in subparagraph (B)) of the threshold amount (as defined in section 59B(e)(1) of the Internal Revenue Code of 1986) applicable to the taxpayer involved.

“(B) APPLICABLE PERCENTAGE.—For purposes of subparagraph (A), the ‘applicable percentage’, for taxable years ending with or within—

“(i) 1998, 1999, or 2000, is 200 percent,

“(ii) 2001 or 2002, is 220 percent, and

“(iii) a year thereafter, is 240 percent.

“(c) INELIGIBLE INDIVIDUAL.—

“(1) MEDICARE PART C ELIGIBLE INDIVIDUAL.—

“(A) IN GENERAL.—The term ‘medicare part C eligible individual’ does not include an individual—

“(i) who is covered under a qualified health plan,

“(ii) subject to paragraph (2), who is entitled to benefits under part A of title XVIII, or

“(iii) whose principal place of abode is in Puerto Rico, the Virgin Islands, Guam, American Samoa, or the Northern Mariana Islands, unless (and only so long as) such possession meets the requirements of paragraph (3)(A).

“(B) CONSTRUCTION.—Nothing in subparagraph (A)(i) shall prevent an individual described in such subparagraph from disenrolling from a plan in order to become a medicare part C eligible individual.

“(2) EXCEPTION FOR MEDICARE SECONDARY PAYER SITUATIONS.—Paragraph (1)(A)(ii) shall not apply to an individual to whom section 1862(b)(2) applies, if the program under this part would otherwise constitute the primary plan (as defined in section 1862(b)(2)(A)).

“(3) RULES RELATING TO POSSESSIONS.—

“(A) REQUIREMENTS.—The requirements of this subparagraph with respect to a possession are that an agreement is in effect between the United States and such possession pursuant to which—

“(i) the laws of such possession impose a qualified medicare part C premium individual share tax (as defined in subparagraph (B));

“(ii) nothing in any provision of law, including the law of such possession, permits such possession to reduce or remit in any way, directly or indirectly, any liability to such possession by reason of such individual share tax;

“(iii) any amount received in the Treasury of such possession by reason of such individual share tax shall be paid (at such time and in such manner as the Secretary of the Treasury shall prescribe) to the Treasury of the United States for credit to the Medicare Part C Trust Fund;

“(iv) such individual share tax is coordinated with the tax imposed by section 59B of the Internal Revenue Code of 1986 such that, for any period, an individual would be required to pay (in the aggregate under both such taxes) not more than the appropriate applicable medicare part C premium for such period; and

“(v) the possession complies with such other requirements as may be prescribed by the Secretary and the Secretary of the Treasury to carry out the purposes of this paragraph, including requirements prescribing the information individuals to whom such individual share tax may apply shall furnish to the Secretary and the Secretary of the Treasury.

“(B) QUALIFIED MEDICARE PART C PREMIUM INDIVIDUAL SHARE TAX.—In subparagraph (A), the term ‘qualified medicare part C premium individual share tax’ means a tax imposed and collected by such a possession that is—

“(i) equivalent to the tax imposed under section 59B of the Internal Revenue Code of 1986 (and any tax subsequently enacted for the purpose of collecting the individual share of premiums for benefits under this part); and

“(ii) imposed on all individuals who are medicare part C eligible individuals (as determined without regard to paragraph (1)(A)(iii)) and who are bona fide residents of the possession, to the extent such individuals have not paid the tax imposed under such section 59B to the United States by reason of subsection (f)(4) of such section or otherwise paid the qualified medicare part C premium individual share tax imposed by another possession under this paragraph.

“SEC. 2302. ENROLLMENT PROCESS.

“(a) IN GENERAL.—The Secretary, through the Health Care Financing Administration, the Social Security Administration, and other appropriate agencies, shall establish a process consistent with section 2384 for—

“(1) determining whether individuals are medicare part C eligible individuals, and

“(2) enrolling medicare part C eligible individuals under this part if they seek such enrollment or are otherwise required to be enrolled or covered under this part.

“(b) PERIOD OF CONTINUOUS OPEN ENROLLMENT.—Any medicare part C eligible individual may enroll under this part at any time beginning July 1, 1997.

“(c) APPLICATION PROCESS.—

“(1) IN GENERAL.—The filing of an application for enrollment under this part shall (except as the Secretary may provide) constitute enrollment under this

part. Such an application may be filed with the Secretary by mail or at such locations as the Secretary may specify.

“(2) AVAILABILITY OF APPLICATIONS.—The Secretary shall make applications for enrollment under this part available—

“(A) at local offices of the Social Security Administration,

“(B) at out-reach sites (such as provider and practitioner locations), and

“(C) at other locations (including post offices) accessible to a broad cross-section of medicare part C eligible individuals.

“(3) COORDINATION WITH APPLICATION FOR PREMIUM SUBSIDIES AND WRAP-AROUND BENEFITS.—An application for enrollment under this part may (but need not) be accompanied by an application for a premium certificate under subpart 1 of part B, wrap-around benefits under subpart 2 of part B, or both.

“(c) CERTAIN INDIVIDUALS DEEMED ENROLLED.—Consistent with rules established under section 2201(c)—

“(1) TERMINATION OF ENROLLMENT UNDER QUALIFIED HEALTH PLAN.—The Secretary shall provide a process under which an eligible individual whose coverage under a qualified health plan is terminated and who fails to establish continuous coverage under another qualified health plan or the medicare program shall be deemed to be enrolled under this part as of the date of termination of such coverage.

“(2) COVERAGE AT BIRTH.—The Secretary shall provide that in the case of an individual born in the United States and who is not enrolled or otherwise covered under a qualified health plan at the time of birth, the individual shall be deemed to have been enrolled under this part at the time of birth.

“SEC. 2303. FACILITATION OF ENROLLMENT.

“(a) IN GENERAL.—The Secretary shall establish procedures that facilitate enrollment under this part.

“(b) COORDINATION.—The Secretary shall coordinate with existing programs and agencies to streamline the enrollment process.

“(c) USE OF CERTAIN PROVIDERS.—

“(1) IN GENERAL.—In accordance with regulations promulgated by the Secretary, hospitals, rural primary care hospitals and federally qualified health centers, and any other health center or clinic receiving Federal funds, shall—

“(A) assist in enrolling under this part individuals who (i) appear to be medicare part C eligible individuals, (ii) are provided services covered under the guaranteed national benefit package, and (iii) do not present a valid health security card, and

“(B) report to the Secretary such information as the Secretary may require to assist in the enrollment of such individuals.

“(2) ACCESS TO INFORMATION.—Such hospitals, centers, and clinics shall have access to information, pertaining to the qualified health plans (or the medicare program or medicare part C) in which individuals are enrolled, through the national enrollment verification system established under subtitle B of title IX of the Health Security Act.

“(d) OUTREACH.—The Secretary shall develop outreach programs to ensure enrollment of all medicare part C eligible individuals (who are not enrolled in a qualified health plan or the medicare program) under this part.

“SEC. 2304. COVERAGE PERIOD; TERMINATION OF ENROLLMENT.

“(a) BEGINNING OF COVERAGE.—In the case of an individual enrolled under this part, the benefits under this part shall first become available for services furnished beginning—

“(1) in the case of an individual who enrolls on or before January 1, 1998, on January 1, 1998; or

“(2) in the case of an individual who enrolls after such date, on the date of enrollment or such other date as the Secretary may specify, consistent with preventing eligible individuals from having any periods of noncoverage and consistent with rules established under section 2201(c).

“(b) LIMITING TERMINATION OF ENROLLMENT.—An individual enrolled under this part may not terminate such enrollment unless—

“(A) the individual is no longer a medicare part C eligible individual because of a change of family, employment, or other relevant status; or

“(B) the individual demonstrates to the satisfaction of the Secretary that if the individual is an eligible individual the individual is enrolled under a qualified health plan, is entitled to benefits under part A of title XVIII, or is described in section 59B(g)(2) of the Internal Revenue Code of 1986.

“Subpart 2—Benefits and Payments

“SEC. 2311. COVERAGE OF BENEFITS UNDER GUARANTEED NATIONAL BENEFIT PACKAGE.

“(a) IN GENERAL.—Subject to subsection (b), the health insurance benefits provided to an individual covered under this part shall consist of entitlement to the benefits (including cost-sharing) contained in the guaranteed national benefit package in the same manner as such package applies to a qualified health plan. Except in the case of enrollment with an organization under section 2332, the cost-sharing schedule shall be the standard cost-sharing schedule described in section 2113 (determined without regard to subsection (a)(4) thereof).

(b) REQUIRING COVERED SERVICES TO BE FURNISHED BY MEDICARE-ELIGIBLE PROVIDERS.—No benefits are payable under this part with respect to an individual or entity that provides items and services unless the individual or entity qualifies for payment with respect to such items or services under title XVIII (for individuals entitled to benefits under such title).

“SEC. 2312. PAYMENTS FOR HEALTH INSURANCE BENEFITS.

“(a) USE OF MEDICARE PAYMENT RULES.—

“(1) IN GENERAL.—Except as otherwise provided in this part, consistent with section 2201(c)(3) of this Act and 8002(c) of the Health Security Act and consistent with the cost-sharing described in section 2311(a)—

“(A) payment of health insurance benefits under this part with respect to services shall be made, subject to adjustment in payment rates under section 2313, in the same amounts and on the same basis as payment may be made with respect to such services under title XVIII (including pursuant to waiver authority), and

“(B) the provisions of sections 1814, 1815, 1833, 1834, 1835, 1842, 1848, 1886, 1887, and 1893 shall apply to payment of benefits (and provision of services and charges thereon) under this part in the same manner as they apply to benefits, services, and charges under title XVIII.

“(2) ESTABLISHMENT OF COMPARABLE PAYMENT METHODS FOR NEW SERVICES.—In the case of any service for which there is not a payment basis established under title XVIII, the Secretary shall establish payment rules that are similar to the payment rules for similar services under such title, in consultation with the Prospective Payment Assessment Commission and the Physician Payment Review Commission.

“(3) LIMITATIONS ON ADMINISTRATIVE OR JUDICIAL REVIEW.—Administrative or judicial review of the payment rates or rules under this section (including adjustments made under section 2313) shall be available only to the extent such a review would be available with respect to such rates or rules (or similar rates or rules) under title XVIII.

“(4) USE OF TRUST FUND.—In applying the provisions described in paragraph (a)(1)(B) in carrying out this section, any reference in title XVIII to a trust fund shall be treated as a reference to the Medicare Part C Trust Fund established under section 2324.

“(b) PAYMENTS TO PROVIDERS FOR CERTAIN EMERGENCY CARE SERVICES FOR INELIGIBLE ALIENS.—

“(1) IN GENERAL.—In addition to amounts otherwise payable under this part, the Secretary shall make payments for care and services that are necessary for the treatment of an emergency medical condition (as defined in section 1867(e)(1)) of an alien who is not an eligible individual.

“(2) PAYMENT AMOUNT.—Notwithstanding any other provisions of this part, the amount of such payments—

“(A) shall not take into account any cost-sharing that may otherwise be imposed under this part, but

“(B) shall be reduced by the amount of any payment otherwise made (or that through the exercise of reasonable collection policies, would have been paid) with respect to such care and services.

“(3) EFFECTIVE DATE.—This subsection shall not apply to care and services furnished before January 1, 2001.

“SEC. 2313. ADJUSTMENTS TO MEDICARE RATES AND METHODOLOGIES.

“(a) ADJUSTMENT OF MEDICARE PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES.—

“(1) FOR PPS HOSPITALS.—For purposes of payment for inpatient hospital services for hospitals receiving payment under section 1886(d), the Secretary, by regulation and in accordance with this section—

“(A) shall adjust the standardized amounts otherwise established under title XVIII to reflect differences in the average cost of providing inpatient

hospital services (included in the guaranteed national benefit package) between the program under part A of title XVIII and under this part, and

“(B) may develop separate diagnosis-related groups and weighting factors for such groups to reflect resource needs of individuals enrolled under this part and shall develop separate groups and factors for children.

“(2) REPORT BY PROSPECTIVE PAYMENT ASSESSMENT COMMISSION.—The Prospective Payment Assessment Commission, in its report to Congress under section 1886(e)(3)(A) in 1997, shall include its recommendations on the adjustments that should be made under paragraph (1) in the payment methodology for inpatient hospital services and data that should be collected in order to establish appropriate weighting factors for diagnosis-related groups used under this section. The Commission shall include, in its subsequent reports under such section, such recommendations with respect to payment for inpatient hospital services under this part as it deems appropriate.

“(3) SECRETARIAL PUBLICATIONS.—The Secretary shall provide for the publication, in the manner and time specified under section 1886(e)(5), of adjustments proposed to be made (and to be made) under this subsection for the calendar year beginning in each fiscal year.

“(b) NEW PROCEDURE CODES AND RELATIVE VALUE UNITS FOR PHYSICIANS’ SERVICES.—

“(1) NEW PROCEDURE CODES AND RELATIVE VALUE UNITS.—In applying section 2312 in the case of services for which relative value units have not been established under section 1848, the Secretary shall establish relative value units in the same manner as if payment for such services were made under part B of title XVIII.

“(2) REPORT BY PHYSICIAN PAYMENT REVIEW COMMISSION.—The Physician Payment Review Commission, in its recommendations to Congress under section 1845(b) in the year before the first year in which this part is effective, shall include recommendations on adjustments to the relative value units that should be applied (under paragraph (1)) with respect to physicians’ services furnished under this part. The Commission shall include, in its subsequent recommendations under such section, such recommendations with respect to the payment for physicians’ services under this part as it deems appropriate.

“(3) SECRETARIAL PUBLICATION.—The Secretary shall cause to be published in the Federal Register—

“(A) before June 1 of the year before the first year in which this part is effective, the relative value units proposed to be applied during such first year under this part, and

“(B) after consideration of public comments submitted pursuant to such proposal and before October 1 before such first year, the relative value units to be applied during such first year under this part.

“(4) SECRETARIAL REVIEW AND REVISION.—The Secretary shall provide for the periodic review and adjustment of the relative value units to be applied under this part in the same manner and frequency as provided under section 1848(c)(2)(B), except that such review shall first be conducted each year during the first 3 years in which this part is in effect and not less often than every 5 years thereafter.

“(c) ADJUSTMENT TO AVERAGE PER CAPITA RATES FOR HEALTH MAINTENANCE ORGANIZATIONS.—For purposes of establishing per capita rates of payment for classes of individuals enrolled with an eligible organization under a risk-sharing contract under section 2332, the Secretary, by regulation and in accordance with this subsection, shall adjust the adjusted average per capita cost otherwise established under section 1876(a)(4) to take into account differences between the population served under title XVIII and the population receiving health insurance benefits under this part.

“SEC. 2314. EXCLUSIONS; COORDINATION.

“(a) EXCLUSIONS.—

“(1) IN GENERAL.—Section 1862 shall apply to expenses incurred for items and services provided under this part in the same manner as such section applies to items and services provided under title XVIII.

“(2) USE OF SAME NATIONAL COVERAGE DECISION REVIEW PROCESS.—The provisions of section 1869(b)(3) shall apply under this part in the same manner as they apply under title XVIII. Any determination under such title that, under paragraph (1), applies under this part shall not be subject to review under this paragraph.

“(b) TREATMENT AS LARGE GROUP HEALTH PLAN FOR PURPOSES OF MEDICARE SECONDARY PAYER.—For purposes of section 1862(b), this part shall be treated as a large group health plan (described in such section).

“Subpart 3—Premiums; Medicare Part C Trust Fund

“SEC. 2321. COMPUTATION OF APPLICABLE MEDICARE PART C PREMIUM.

“(a) IN GENERAL.—The applicable medicare part C premium under this part, for health insurance benefits for any individual in a class of enrollment (as defined in section 3(b) of the Health Security Act) in a State (or outside the United States) for a month in a year, is equal to the product of—

“(1) the monthly national actuarial rate established under subsection (b) with respect to such class for months in the year, and

“(2) a State actuarial adjustment factor established under subsection (c) with respect to the State (or outside the United States).

The Secretary shall publish, for purposes of sections 59B(c)(3)(D) and 3455(c)(4)(A) of the Internal Revenue Code of 1986, tables of the monthly applicable medicare part C premium computed under this subsection.

“(b) MONTHLY NATIONAL ACTUARIAL RATES.—

“(1) INITIAL RATE.—Subject to the succeeding provisions of this subsection, the national monthly actuarial rates under this subsection for months in 1998 are as follows:

“(A) INDIVIDUAL ENROLLMENT.—\$____ for the individual class of enrollment.

“(B) SINGLE PARENT ENROLLMENT.—\$____ for the single parent class of enrollment.

“(C) FAMILY ENROLLMENT.—\$____ for the family class of enrollment.

“(2) DETERMINATION OF RATES.—

“(A) ANNUAL DETERMINATION.—In September of each year (beginning with 1997) the Secretary shall determine and publish a national monthly actuarial rate for each class of enrollment for health insurance benefits under this part in the following year. Such rates for—

“(i) 1998 shall be the rates specified under paragraph (1), subject to adjustment under subparagraph (C), or

“(ii) a subsequent year shall be the monthly actuarial rates estimated under paragraph (3).

“(B) PUBLIC STATEMENT.—Whenever the Secretary publishes monthly actuarial rates under this section, the Secretary shall, at the time of such publication, include a public statement setting forth the actuarial assumptions and bases employed in arriving at the amount of the actuarial rates.

“(C) RELATION TO SPECIFIED RATES.—If the Secretary finds that the rates specified under paragraph (1) are greater or less than the respective monthly actuarial rates estimated under paragraph (3), the Secretary shall adjust the specified rates to reflect such estimated actuarial rates and the national monthly actuarial rates under this subsection shall be treated for all purposes as the rates as so adjusted.

“(3) BASIS FOR MONTHLY ACTUARIAL RATES.—

“(A) IN GENERAL.—Subject to subparagraph (C), each such monthly actuarial rate established for a class of enrollment shall be an amount the Secretary estimates to be necessary so that, if payments were made on the basis of such rates for all individuals enrolled under this part in such class, the aggregate amount for the calendar year would equal the total of the benefits and administrative costs which the Secretary estimates will be payable from the Medicare Part C Trust Fund for services performed and related administrative costs incurred in such calendar year with respect to such enrollees. In calculating the monthly actuarial rates, the Secretary shall include an appropriate amount for a contingency margin.

“(B) ASSUMPTIONS FOR PREMIUM CALCULATION.—In determining actuarial rates under subparagraph (A)—

“(i) the Secretary shall not take into account any expenditures (including related administrative expenses) attributable to—

“(I) individuals enrolled for health insurance benefits under this part who are SSI recipients who have been determined to be disabled for purposes of the supplemental security income program (under title XVI); or

“(II) the operation of part B of this title; or

“(III) payments made pursuant to section 2312(b); and

"(ii) for months in 1998, 1999, 2000, and 2001, the Secretary shall assume that $\frac{3}{4}$ of individuals who are medicare part C eligible individuals are enrolled under this part.

"(c) STATE ACTUARIAL ADJUSTMENT FACTORS.—

"(1) IN GENERAL.—The Secretary shall establish for each State a State actuarial adjustment factor. Such factor shall vary among the States based on the variation in the average level of benefits and administrative costs, described in subsection (b)(3)(B) and determined on a per capita basis, among such States.

"(2) CONDITIONS.—State actuarial adjustment factors shall be computed for each year in a manner so that the application of such adjustment factors shall not change the weighted average of the national monthly payment rates computed under this subsection.

"(3) SPECIAL RULE FOR INDIVIDUALS RESIDING OUTSIDE THE UNITED STATES.—In the case of an individual who has a principal place of abode outside the United States, the State actuarial adjustment factor under this subsection is 1.

"(d) APPLICATION TO FAMILIES.—In the case of individuals enrolled under this part in a class of enrollment other than the individual class of enrollment, the premium rate established under this section applies collectively to all family members included within the class of enrollment.

"SEC. 2322. MEDICARE PART C PREMIUM LIABILITY.

"(a) IN GENERAL.—Individuals enrolled for benefits under this part are for payment of the individual share of medicare part C premiums in the amount provided under section 59B of the Internal Revenue Code of 1986.

"(b) DESCRIPTION OF FACTORS TAKEN INTO ACCOUNT.—The amount of such individual share under such section—

- "(1) is based on the sum of monthly premiums based on class of enrollment;
- "(2) is fully or partially reduced for low-income individuals; and
- "(3) may be reduced by any employer payments.

"SEC. 2323. COLLECTION OF PREMIUMS.

"(a) IN GENERAL.—Except as provided in subsection (b), the amounts under section 2322 are payable pursuant to section 59B of the Internal Revenue Code of 1986.

"(b) DIRECT PAYMENT PROCESS.—

(1) IN GENERAL.—The Secretary shall establish a process whereby individuals who are liable for payments under section 2322 (or section 59B of the Internal Revenue Code of 1986) may make such payments directly to the Secretary (or the Secretary's designee) in a manner specified by the Secretary.

"(2) INFORMATION.—Under the process, the Secretary shall provide such information return or other documentation that may be used to establish, for purposes of the Internal Revenue Code of 1986 or otherwise, the amounts paid on behalf of each individual under this subsection and the period in which the individual was enrolled under this part.

"(3) DEPOSIT.—Amounts received under this subsection shall be deposited to the credit of the Medicare Part C Trust Fund (established under section 2324).

"SEC. 2324. MEDICARE PART C TRUST FUND.

"(a) ESTABLISHMENT.—

"(1) IN GENERAL.—There is hereby created on the books of the Treasury of the United States a trust fund to be known as the 'Medicare Part C Trust Fund' (in this section referred to as the 'Trust Fund'). The Trust Fund shall consist of such gifts and bequests as may be made as provided pursuant to section 201(h) and such amounts as may be deposited in, or appropriated to, such Trust Fund as provided in this subpart.

"(2) DEPOSIT OF PREMIUM AMOUNTS AND CONTRIBUTIONS.—There are hereby appropriated to the Trust Fund amounts equivalent to 100 percent of—

"(A) the amounts received in the Treasury under section 59B and chapter 25 of the Internal Revenue Code of 1986,

"(B) the amount of payments made by States to the Secretary under sections 8111, 8121, and 8131 of the Health Security Act, and

"(C) amounts paid to the Treasury pursuant to agreements under section 2301(c)(3)(A).

The amounts appropriated by clauses (A) and (C) of the preceding sentence shall be transferred from time to time from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the amounts paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the amounts specified in such clauses.

“(3) APPROPRIATIONS TO COVER BALANCE OF EXPENDITURES.—There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Medicare Part C Trust Fund a Government contribution equal to the amount by which the expenditures from the Trust Fund (including the payment of administrative expenses in accordance with section 201(g)(1)) exceed the other receipts of the Trust Fund.

“(b) INCORPORATION OF PROVISIONS.—

“(1) IN GENERAL.—Subject to paragraph (2), the provisions of subsections (b) through (e), (h), and (i) of section 1817 shall apply to the Trust Fund and this part in the same manner as they apply to the Federal Hospital Insurance Trust Fund and part A of title XVIII.

“(2) EXCEPTIONS.—In applying paragraph (1)—

“(A) the Board of Trustees and Managing Trustee of the Trust Fund shall be composed of the members of the Board of Trustees and the Managing Trustee, respectively, of the Federal Hospital Insurance Trust Fund; and

“(B) any reference in section 1817 to the Federal Hospital Insurance Trust Fund or to title XVIII (or part A thereof) is deemed a reference to the Trust Fund under this section and this part, respectively.

“(c) ADDITIONAL PAYMENTS.—

“(1) PAYMENTS UNDER PART B.—In addition to payments made pursuant to authority described in section 1817(h) (as incorporated under subsection (b)(1)), the Managing Trustee of the Trust Fund shall pay from time to time from the Trust Fund such amounts as the Secretary certifies are necessary to make—

“(A) the payments under premium certificates issued under subpart 1 of part B,

“(B) the payments provided for by subpart 2 of part B, and

“(C) payments to State benefit management programs approved under subtitle B of title IV of the Health Security Act (on such a periodic basis as the Secretary may establish) in the sum of—

“(i) the amount described in section 4104(a)(1)(B) of the Health Security Act;

“(ii) the amount described in section 4104(a)(2)(B) of such Act; and

“(iii) the amount described in section 4104(b)(2)(B) of such Act.

“(2) CERTAIN TRANSFERS.—The Managing Trustee of the Trust Fund shall also pay from time to time from the Trust Fund to the General Treasury such amounts as the Secretary of the Treasury certifies to be payments for credits under section 3461 and 3462 of the Internal Revenue Code of 1986 that are not an offset to a liability in amounts otherwise payable under chapter 25 of such Code.

“Subpart 4—Administrative Provisions

“SEC. 2331. AGREEMENTS WITH HOSPITALS; PARTICIPATING PHYSICIANS; TREATMENT OF INDIAN HEALTH SERVICE FACILITIES.

“(a) REQUIREMENT.—Any hospital shall be qualified to participate under this part and shall be eligible for payments under this part if—

“(1) it has in effect a participation agreement under section 1866(a)(1), and

“(2) it files with the Secretary a participation agreement meeting the requirements of subsection (b).

“(b) ELEMENTS OF AGREEMENT.—

“(1) IN GENERAL.—Except as provided in this subsection, a participation agreement under this subsection shall provide terms, specified by the Secretary, that are the same terms as those required of hospital participation agreements under section 1866(a)(1).

“(2) MODIFIED COPAYMENTS.—Instead of the limitation on charges specified under paragraphs (1)(A) and (2) of section 1866(a), the agreement shall not permit the hospital to charge more than the applicable deductible and coinsurance permitted under this part.

“(c) PHYSICIAN PARTICIPATION AGREEMENTS.—The Secretary shall provide for participating physician agreements under this part in the same manner as such agreements are provided for under part B of title XVIII pursuant to section 1842(h).

“(d) INDIAN HEALTH SERVICE FACILITIES.—The provisions of section 1880 (relating to Indian health service facilities) shall apply to this part in the same manner as they apply under title XVIII.

“SEC. 2332. HEALTH MAINTENANCE ORGANIZATIONS.

“(a) IN GENERAL.—Except as provided in this section, section 1876 shall apply to individuals enrolled under this part in the same manner as such section applies to

individuals entitled to benefits under part A, and enrolled under part B, of title XVIII.

“(b) APPLICATION.—In applying section 1876 under subsection (a)—

“(1) individuals who are enrolled in a class of enrollment under this part may enroll with an eligible organization only based on the same class of enrollment;

“(2) if an eligible organization imposes an additional premium for additional benefits, such a premium shall be adjusted to reflect the class of enrollment with the eligible organization;

“(3) the appropriate classes of members described in section 1876(a)(1)(B) applied under this section may be different from the classes applied for purposes of title XVIII;

“(4) the provisions of such section relating only to individuals enrolled under part B of title XVIII shall not apply;

“(5) any reference to a Trust Fund established under title XVIII and to benefits with respect to any services under such title is deemed a reference to the Medicare Part C Trust Fund and to the guaranteed national benefit package with respect to required health services under this part;

“(6) the adjusted average per capita cost shall be determined on the basis of benefits under this part;

“(7) subsection (h) shall not apply; and

“(8) in the case of a risk-sharing contract, the eligible organization may not require an enrollee to obtain a referral from a physician in order to obtain covered items and services from a physician who specializes in obstetrics and gynecology.

“SEC. 2333. USE OF FISCAL AGENTS.

“(a) USE OF FISCAL AGENTS.—

“(1) IN GENERAL.—Except as provided in this section, the Secretary shall provide for the administration of this part through the use of fiscal agents in the same manner as title XVIII is carried out through the use of fiscal intermediaries and carriers.

“(2) SEPARATE CONTRACTS.—Contracts with fiscal agents entered into pursuant to this subsection for an area need not be with the same fiscal intermediary or carrier with an agreement under section 1816 or a contract under section 1842 for the area. However, nothing in this section shall be construed as preventing such an organization with such an agreement or contract under such respective section from entering into a contract under this section.

“SEC. 2334. COMPLIANCE WITH QUALITY ASSURANCE AND INFORMATION STANDARDS; SURVEY AND CERTIFICATION.

“(a) IN GENERAL.—The Secretary, with respect to the program under this part, shall comply with the applicable provisions of—

“(1) subtitle A of title IX of the Health Security Act (relating to the national quality management program), and

“(2) subtitle B of such title (relating to information systems and administrative simplification).

“(b) SURVEY AND CERTIFICATION; QUALITY ASSURANCE.—In accordance with rules of the Secretary, the survey and certification requirements of title XVIII, and the quality assurance provisions of such title and part B of title XI (relating to professional review organizations), insofar as they relate to providers of services and other health care providers under title XVIII, shall apply to such providers under this part in the same manner as they apply to providers under title XVIII.

“SEC. 2335. PROGRAM INTEGRITY

Sections 1124, 1124A, 1126, and 1128 through 1128B (relating to fraud and abuse) and section 1877 (relating to limitation on certain physician referrals) shall apply to this title in the same manner as they apply to title XVIII.

“SEC. 2336. GENERAL ADMINISTRATION; MISCELLANEOUS PROVISIONS.

“(a) HEALTH SECURITY ADMINISTRATION.—

“(1) IN GENERAL.—Except as otherwise provided in this part, this part shall be administered by the Health Security Administration.

“(2) RENAMING HEALTH CARE FINANCING ADMINISTRATION AS HEALTH SECURITY ADMINISTRATION.—Any reference in law to the ‘Health Care Financing Administration’ is hereby deemed a reference to the ‘Health Security Administration’.

“(b) REGULATIONS; TITLE II PROVISIONS; ADMINISTRATION.—The provisions of sections 1871, 1872, and 1874 (relating to regulations, application of certain provisions of title II, and administration) shall apply to this part in the same manner as they apply to title XVIII.

“(c) DETERMINATIONS; APPEALS; PROVIDER REIMBURSEMENT REVIEW BOARD.—

“(1) DETERMINATIONS.—The determination of whether an individual is entitled to benefits under this part and the determination of the amount of benefits under this part shall be made by the Secretary in accordance with regulations prescribed by the Secretary.

“(2) HEARINGS.—

“(A) IN GENERAL.—Any individual dissatisfied with any determination under paragraph (1) shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary’s final decision after such hearing as is provided in section 205(g). Sections 206(a), 1102, and 1871 (as incorporated by reference by subsection (b)) shall not be construed as authorizing the Secretary to prohibit an individual from being represented under this paragraph by a person that furnishes the individual, directly or indirectly, with services solely on the basis that the person furnishes the individual with such a service. Any person that furnishes services to an individual may not represent an individual under this paragraph with respect to the issue described in section 1879(a)(2) unless the person has waived any rights for payment from the beneficiary with respect to the services involved in the appeal. If a person furnishes services to an individual and represents the individual under this paragraph, the person may not impose any financial liability on such individual in connection with such representation.

“(B) LIMITATION.—Notwithstanding subparagraph (A), a hearing shall not be available to an individual if the amount in controversy is less than \$500 and judicial review shall not be available to the individual if the amount in controversy is less than \$1,000. In determining the amount in controversy, the Secretary, under regulations, shall allow two or more claims to be aggregated if the claims involve the delivery of similar or involve related services to the same individual or involve common issues of law and fact arising from services furnished to two or more individuals.

“(C) EXPEDITED REVIEW.—In an administrative hearing pursuant to subparagraph (A), where the moving party alleges that there are no material issues of fact in dispute, the administrative law judge shall make an expedited determination as to whether any such facts are in dispute and, if not, shall determine the case expeditiously.

“(3) PROVIDER REIMBURSEMENT REVIEW BOARD.—The provisions of section 1878 (relating to the Provider Reimbursement Review Board) shall apply under this part in the same manner as they apply under title XVIII.

“(d) REPORTING OF INFORMATION TO SECRETARY OF TREASURY.—The Secretary shall submit to the Secretary of the Treasury such information on individuals enrolled under this part as the Secretary of the Treasury may require for purposes of carrying out section 59B and chapter 25, and related provisions, of the Internal Revenue Code of 1986.

“Subpart 5—Definitions and Miscellaneous

“SEC. 2361. DEFINITIONS.

“In this part—

“(1) the definitions contained in section 1861 apply for purposes of this part in the same manner as they apply for purposes of title XVIII;

“(2) the definitions contained in sections 2 and 3 (relating to general definitions and definitions relating to families) of the Health Security Act apply for purposes of this part in the same manner as they apply for purposes of such Act.”.

(b) CONFORMING AMENDMENTS.—

(1) IN GENERAL.—Section 1876(f) (42 U.S.C. 1395mm(f)) is amended by striking “under a State plan approved under title XIX” and inserting “under part A of title XXIII” each place it appears.

(2) RENAMING OF HEALTH CARE FINANCING ADMINISTRATION.—Section 1117 is amended—

(A) in the heading, by striking “HEALTH CARE FINANCING ADMINISTRATION” and inserting “HEALTH CARE SECURITY ADMINISTRATION”, and

(B) by striking “Health Care Financing Administration” and inserting “Health Security Administration”.

(3) ADMINISTRATIVE EXPENSES.—Section 201 (42 U.S.C. 401) is amended—

(A) in subsection (g)(1)(A), by inserting “and the Medicare Part C Trust Fund established by part A of title XXIII” after “title XVIII” in the matter before clause (i);

(B) in subsection (g)(1), by striking “and XVIII” and “and title XVIII” each place either appears and inserting “XVIII, and XXIII” and “title XVIII, and title XXIII”, respectively; and

(C) in subsection (h), by striking “and the Federal Supplementary Medical Insurance Trust Fund” and inserting “the Federal Supplementary Medical Insurance Trust Fund, and the Medicare Part C Trust Fund”.

(4) DEFINITION OF STATE.—Section 11Q1(a)(1) of the Social Security Act (42 U.S.C. 1301(a)(1)) is amended by inserting “or title XXIII” after “Such term when used in title XX”.

(c) EFFECTIVE DATE.—Part A of title XXIII of the Social Security Act, as added by subsection (a), shall take effect on the date of the enactment of this Act, except that no benefits shall be provided under such part for services furnished before January 1, 1998.

SEC. 8002. DEVELOPMENT AND IMPLEMENTATION OF PROSPECTIVE PAYMENT METHODOLOGIES.

(a) IN GENERAL.—Subject to subsection (b), the Secretary shall, not later than January 1, 1997, develop and implement prospective payment methodologies for setting payment rates for services for which a prospective payment methodology is not used under the medicare program. In developing such methodologies, the Secretary shall ensure that the amount of payments under such methodologies under the medicare program would not exceed the amount of payments that would be paid under the methodologies otherwise applicable.

(b) PAYMENT METHODOLOGIES FOR PPS-EXEMPT HOSPITALS.—The Secretary shall develop and implement such a payment methodology for services of classes of hospitals (including children's hospitals) that are not subsection (d) hospitals (within the meaning of section 1886(d)(1)(B) of the Social Security Act) where appropriate. Any such payment methodology shall provide for hospital-specific payment rates based on resource requirements of such hospitals, determined using data specific to the different classes of such hospitals.

(c) APPLICATION OF METHODOLOGIES.—In the case of any service within a class of services for which a prospective payment methodology is implemented under subsection (a), notwithstanding any other provision of law, such methodology shall be applied under the medicare program and medicare part C and under subtitle D of title VI instead of the methodology otherwise provided.

SEC. 8003. DEVELOPMENT OF METHODOLOGY FOR ESTABLISHING LIMITS ON PAYMENTS FOR SERVICES PROVIDED IN HOSPITAL OUTPATIENT DEPARTMENTS.

The Secretary shall revise the payment methodology established under the medicare program for payment for services provided in hospital outpatient departments in order to provide for a hospital-specific limit on the rate of growth in payments for such services. Such revision shall first be applied to payments to hospitals for portions of cost reporting periods occurring on or after January 1, 1996, and before the date of implementation of a prospective payment system for such services under section 8002.

Subtitle B—Benefits for Low-Income Individuals; State Maintenance of Effort

PART 1—PREMIUM CERTIFICATES AND WRAP-AROUND BENEFITS FOR LOW-INCOME INDIVIDUALS

SEC. 8101. PREMIUM CERTIFICATES FOR LOW-INCOME INDIVIDUALS COVERED UNDER EMPLOYER HEALTH PROGRAMS.

(a) IN GENERAL.—Title XXIII, as added by section 8001, is amended by adding at the end the following new part:

“PART B—ASSISTANCE FOR LOW-INCOME INDIVIDUALS

“Subpart 1—Premium Certificate Program for Low-Income Individuals Covered Under Employer Health Programs

“SEC. 2371. ELIGIBILITY.

“(a) IN GENERAL.—Each premium certificate eligible individual is entitled to be issued a premium certificate in accordance with this subpart.

“(b) PREMIUM CERTIFICATE ELIGIBLE INDIVIDUAL.—

“(1) IN GENERAL.—In this subpart, the term ‘premium certificate eligible individual’ means an eligible individual who is an employee (as defined for purposes of chapter 25 of the Internal Revenue Code of 1986) and who—

“(A) with respect to premiums for a taxable year ending in a year, is determined, under subpart 2 in the manner described in section 2384, to have projected modified adjusted gross income that is less than the applicable percentage (specified in section 2301(b)(5)(B)) of the threshold amount (as defined in section 59B(e)(1) of the Internal Revenue Code of 1986) applicable to the taxpayer involved; or

“(B) with respect to a premium for a month, is an AFDC or SSI recipient (as defined in section 2 of the Health Security Act) in the month.

“(2) EXCEPTION.—

“(A) IN GENERAL.—Such term does not include an individual—

“(i) who is entitled to benefits under the medicare part C program under part A of this title and is entitled to an exemption from, or a reduction in, medicare part C premium liability under section 59B(b) of the Internal Revenue Code of 1986;

“(ii) who is entitled to benefits under part A of title XVIII;

“(iii) subject to subparagraph (B), who is covered under a State benefit management program under subtitle B of title IV of the Health Security Act; or

“(iv) whose only enrollment in a qualified health plan is in a plan that is a high deductible plan (as defined in section 2204(5)).

“(B) CONTINUED APPLICATION IN CASE OF CERTAIN ELECTION.—Subparagraph (A)(iii) shall not apply in the case of a State which has made the election described in section 4104(a)(1)(A)(ii) of the Health Security Act.

“SEC. 2372. VALUE OF PREMIUM CERTIFICATE.

“The value of the premium certificate issued under this subpart to an employee is equal to the lesser of—

“(1) the employee’s premium obligation under—

“(A) the qualified health plan of the employer that covers the employee, or

“(B) a State benefit management program for which the election described in section 4104(a)(1)(A)(ii) of the Health Security Act is in effect (in the case of an employee covered under such a program); or

“(2) the amount of the reduction that would occur in the medicare part C premium liability (under section 59B of the Internal Revenue Code of 1986) for the taxpayer under subsection (b) of such section if the taxpayer were a medicare part C covered individual.

“SEC. 2373. ADMINISTRATION OF PROGRAM.

“(a) IN GENERAL.—The Secretary shall establish a program to provide for the issuance of premium certificates, in the amount described in section 2372, to premium certificate eligible individuals. Under the program the Secretary shall—

“(1) determine if individuals are premium certificate eligible individuals, and

“(2) provide for issuance of premium certificates to individuals determined to be premium certificate eligible individuals.

“(c) APPLICATION FOR CERTIFICATE.—

“(1) IN GENERAL.—Any eligible individual may apply for a premium certificate under this subpart by filing an application with the Secretary through a local office of the Social Security Administration.

“(2) ATTACHMENTS.—

“(A) IN GENERAL.—The Secretary shall require attachments to the application of such documentation (such as prior year tax forms and pay stubs) as may be needed to determine the individual’s eligibility and the value of any premium certificate.

“(B) EMPLOYER DOCUMENTATION.—The Secretary shall specify, for purposes of section 3466(d)(4) of the Internal Revenue Code of 1986, the form and manner of documentation required of employers under such section with respect to their employees.

“(d) DETERMINATIONS.—

“(1) IN GENERAL.—The Secretary shall provide for—

“(A) prompt determination, on each application made under subsection (c), of eligibility of an applicant and the value of any premium certificate for the applicant, and

“(B) prompt notification of the applicant of such determinations.

“(2) CONDITION OF CERTIFICATE.—Each certificate issued to an individual under this section is conditioned upon the individual reporting to the Secretary

(in a form and manner specified by the Secretary) any change in status that would affect the individual's eligibility for such a certificate or the amount of the certificate.

“(e) ISSUANCE AND USE OF CERTIFICATES.—

“(1) ISSUANCE.—The Secretary shall issue a premium certificate to each employee determined to be a premium certificate eligible individual under this section.

“(2) TENDER TO EMPLOYERS.—

“(A) REDUCTION OF EMPLOYEE PREMIUMS.—Upon the tender of such certificate by an employee to an employer, the employer is required under section 3466(d)(4)(B) of the Internal Revenue Code of 1986 to reduce the amount of premiums required to be paid by the employee.

“(B) SUBMISSION TO SECRETARY AND REMISSION OF VALUE TO EMPLOYER.—The employer may tender such a certificate to the Secretary, in a manner specified by the Secretary, and, upon such tender, is entitled to receive the value of the certificate so tendered.

“(3) DIRECT PAYMENT OF CERTAIN ASSISTANCE.—The Secretary shall provide for a payment directly to an employee whose application is approved of an amount equal to the amount of the reduction in premium that would have been provided with respect to the individual for the month in which the application was filed if the certificate had been issued (and tendered to the individual's employer) on the first day of such month.

“(f) VERIFICATION.—

“(1) IN GENERAL.—The Secretary shall periodically verify information reported on applications under this section, using any or all of the following:

“(A) The enrollment verification system established under subtitle B of title IX of the Health Security Act.

“(B) Information reported by the States administering benefits for AFDC and SSI recipients.

“(C) Information reported on ‘W-2 forms’ and maintained by the Social Security Administration.

“(D) Information, provided by the Secretary of the Treasury upon request of the Secretary, including information returns and other information filed with the Internal Revenue Service.

“(E) Other information deemed to be necessary.

“(2) RECONCILIATION.—

“(A) EXCESS PAYMENTS.—If the Secretary determines, based upon tax return and other information described in paragraph (1), that the value of a certificate issued exceeded the correct value of the certificate or that an individual who was issued a certificate was not a premium certificate eligible individual, the Secretary shall—

“(i) adjust the value of the certificate to recoup, over a reasonable period of time, the amount of the overpayment, or

“(ii) if the individual is no longer a premium certificate eligible individual, bill the individual for the amount of the excess value and for interest on any amount so billed that is not repaid on a timely basis.

“(B) DEFICIT PAYMENTS.—If the Secretary determines, based upon tax return and other information described in paragraph (1), that the value of a certificate issued was less than the correct value of the certificate, the Secretary shall—

“(i) pay directly to the individual the amount of the underpayment, or

“(ii) if the individual continues to be a premium certificate eligible individual, adjust the value of the certificate, as appropriate.

“(g) PENALTIES FOR MISREPRESENTATION.—Any individual who knowingly makes a material misrepresentation of information in an application for a premium certificate under this section would be liable for excess payments made based upon such misrepresentation and interest on such excess payments, at a rate specified by the Secretary. In addition, such individuals would be subject to a civil monetary penalty of \$1,000, or, if greater, three times the amount of excess payments made based on such misrepresentations. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under this subsection in the same manner as they apply to a penalty or proceeding under section 1128A(a).”

(b) EFFECTIVE DATE.—No premium certificate shall be made available under subpart 1 of part B of title XXIII of the Social Security Act, added by subsection (a), for premiums for months before January 1998.

SEC. 8102. WRAP-AROUND BENEFITS FOR LOW-INCOME INDIVIDUALS.

(a) **IN GENERAL.**—Title XXIII of the Social Security Act, as added by section 8001 and as amended by section 8101, is amended by adding at the end the following new subpart:

“Subpart 2—Wrap-Around Benefits for Low-Income Individuals

“SEC. 2381. ELIGIBILITY.

“(a) **IN GENERAL.**—Subject to subsection (c), each individual who applies for benefits under this subpart and is determined under this subpart to be a wrap around eligible individual described in subsection (b) is entitled to a supplemental benefits in accordance with this subpart, without regard to whether the individual is enrolled under part A.

“(b) **WRAP AROUND ELIGIBLE INDIVIDUAL.**—

“(1) **IN GENERAL.**—In this subpart, the term ‘wrap around eligible individual’ means any of the following individuals:

“(A) **INDIVIDUALS WITH INCOME BELOW POVERTY LEVEL.**—An individual who is determined under this subpart to have projected modified adjusted gross income that is less than the threshold amount (as defined in section 59B(e)(1) of the Internal Revenue Code of 1986) applicable to the taxpayer involved.

“(B) **AFDC AND SSI RECIPIENTS.**—An AFDC recipient or SSI recipient.

“(C) **CHILDREN AND PREGNANT WOMEN WITH INCOME BELOW 200 PERCENT OF POVERTY LEVEL.**—Any of the following individuals if the individual is determined under this subpart to have projected modified adjusted gross income that is less than twice the threshold amount (as defined in section 59B(e)(1) of the Internal Revenue Code of 1986) applicable to the taxpayer involved:

“(i) A child under 19 years of age.

“(ii) A pregnant woman.

For purposes of clause (ii), a woman shall be deemed to be a pregnant woman during the period ending on the first day of the first month that begins more than 60 days after the date of the termination of the pregnancy.

“(2) **EXCEPTIONS.**—

“(A) **IN GENERAL.**—Such term does not include an individual—

“(i) who is entitled to benefits under part A of title XVIII,

“(ii) subject to subparagraph (B), who is covered under a State benefit management program under subtitle B of title IV of the Health Security Act, or

“(iii) whose only enrollment in a qualified health plan is in a plan that is a high deductible plan (as defined in section 2204(5)).

“(B) **SPECIAL RULE.**—Subparagraph (A)(ii) shall not apply in the case of a State which has made the election described in section 4104(b)(1)(B) of the Health Security Act.

“(c) **SPECIAL RULES FOR CASH ASSISTANCE RECIPIENTS.**—

“(1) **IN GENERAL.**—An individual who is an AFDC recipient or SSI recipient is deemed to be entitled to benefits under this subpart, without the need to file an application under this subpart, for items and services furnished during the period in which the individual is receiving assistance.

“(2) **COORDINATION.**—The Secretary shall provide for a method under which individuals who are determined to be AFDC recipients or SSI recipients are notified of the benefits to which they are entitled under this subpart and any applicable procedures for obtaining evidence of their entitlement.

“(d) **AFDC RECIPIENT AND SSI RECIPIENT DEFINED.**—In this subpart, the terms ‘AFDC recipient’ and ‘SSI recipient’ have the meanings given such terms in section 2 of the Health Security Act.

“SEC. 2382. WRAP-AROUND BENEFITS.

“(a) **BENEFITS.**—The benefits provided to a wrap around eligible individual under this subpart consist of the following (subject to subsection (e)):

“(1) **WAIVER OF COST-SHARING.**—The payment for any cost sharing (described in part B of title XXI) otherwise applicable to items and services covered under the guaranteed national benefit package.

“(2) **EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT SERVICES.**—For individuals under 19 years of age, payment for those early and periodic screening, diagnostic, and treatment services (as defined in section 1905(r)) that are not covered under the guaranteed national benefit package.

"(3) VISION AND HEARING CARE.—Payment for vision and hearing care, including eyeglasses and hearing aids, that are not covered under the guaranteed national benefit package.

The Secretary shall establish standards with respect to the items and services specified in paragraphs (2) and (3). In this subpart, the term 'guaranteed national benefit package' means the package of health benefits described in title XXI.

"(b) PAYMENT AMOUNTS.—

"(1) COST-SHARING.—Payments for cost-sharing under subsection (a)(1) for an item or service shall be based upon the cost-sharing amounts that would apply to the item or service if the individual were enrolled under part A, without regard to whether the individual is enrolled under such part.

"(2) ADDITIONAL SERVICES.—Payments for items and services described in paragraph (2) or (3) of subsection (a)—

"(A) for which there are payment amounts established under part A shall be based on the payment amounts established under such part; or

"(B) for which there are not such payment amounts established, shall be based on payment amounts established by the Secretary, in consultation with the Prospective Payment Assessment Commission and the Physician Payment Review Commission, taking into account the payment rules established for similar items and services under part A.

"(c) SECONDARY PAYER TO QUALIFIED HEALTH PLANS.—The provisions of section 1862(b) shall apply to benefits under this subpart in the same manner as they apply to benefits under title XVIII.

"(d) USE OF MEDICARE PART C CLAIMS PROCESS.—

"(1) COST-SHARING FOR INDIVIDUALS ENROLLED UNDER MEDICARE PART C.—In the case of individuals entitled to benefits under this subpart and enrolled under part A, the benefits for cost-sharing under subsection (a)(1) with respect to an item or service shall be provided simultaneous with the payment of benefits with respect to such item or service under such part.

"(2) OTHER BENEFITS.—Except as provided in paragraph (1), claims for payment for benefits under this subpart shall be made and processed in the same manner as claims for payment for benefits under part A.

"(3) EXTENSION OF AGREEMENTS WITH FISCAL AGENTS.—The Secretary shall provide for extension of such agreements with fiscal agents under such part as may be appropriate to carry out this subsection.

"(e) SPECIAL RULES FOR INDIVIDUALS ENROLLED IN STATE MANAGED MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAMS.—

"(1) COVERAGE OF SERVICES THROUGH THE STATE PROGRAM.—In the case of a wrap around eligible individual who is enrolled in a State managed mental health and substance abuse program approved under section 4201 of the Health Security Act for a month—

"(A) the individual is considered to have waived the right to benefits described in paragraph (3) under this subpart in consideration of receipt of benefits for mental health and substance abuse services through such program;

"(B) the Secretary shall make a per capita payment to the State, in the amount specified in paragraph (2), on behalf of the individual; and

"(C) no other payment may be made under this subpart with respect to such services furnished to the individual during the month.

Payments under subparagraph (B) shall be made not less frequently than monthly.

"(2) CAPITATED PAYMENTS AMOUNTS.—The amount of the per capita payment provided under paragraph (1)(B) shall be an amount determined in accordance with a methodology established by the Secretary (similar to the methodology used under section 1893(b) to determine capitated payments to States on behalf of medicare beneficiaries enrolled in such State programs) that reflects the costs associated with the benefits described in paragraph (3) that would be provided to the individual under this subpart if the individual were not enrolled in the State managed mental health and substance abuse program.

"(3) MENTAL HEALTH AND SUBSTANCE ABUSE AND SUBSTANCE ABUSE BENEFITS DESCRIBED.—The benefits described in this paragraph are as follows:

"(A) MENTAL HEALTH AND SUBSTANCE ABUSE AND SUBSTANCE ABUSE COST SHARING.—Payment of cost sharing described in subsection (a)(1) with respect to mental health and substance abuse services (as defined in section 1893(c)) covered under the guaranteed national benefit package.

“(B) MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES INCLUDED IN EPSDT.—Benefits under subsection (a)(2) with respect to such mental health and substance abuse services.

“(f) PAYMENT BY MEDICARE PART C TRUST FUND.—Benefits provided under this subpart shall be paid from the Medicare Part C Trust Fund.

“SEC. 2383. APPLICATION FOR BENEFITS.

“(a) FORM.—

“(1) IN GENERAL.—An application for benefits under this subpart shall be made in such form and manner as the Secretary shall specify consistent with this section.

“(2) INFORMATION.—The application shall require—

“(A) the provision of information necessary to determine eligibility for benefits under this subpart, and

“(B) the provision of information respecting whether the individual is enrolled under part A and the qualified health plan (if any) in which the individual is enrolled.

“(b) AVAILABILITY OF APPLICATIONS.—The Secretary shall make applications for benefits under this subpart available in the same manner as the Secretary makes available applications for enrollment under part A.

“(c) COORDINATION WITH PART C ENROLLMENT APPLICATION.—An application for benefits under this subpart may (but need not) be accompanied by an application for enrollment under part A or for a premium certificate under subpart 1 on the basis of being a low-income individual.

“(d) FACILITATION OF APPLICATIONS FOR BENEFITS.—The provisions of section 2303 shall apply to wrap around eligible individuals and applications for benefits under this subpart in the same manner as such provisions apply to medicare part C eligible individuals and applications for enrollment under part A.

“(e) FREQUENCY OF APPLICATION.—An application for benefits under this subpart may be filed at any time during the year.

“SEC. 2384. DETERMINATION OF ELIGIBILITY.

“(a) PROCESS.—The Secretary, through the Social Security Administration and other appropriate agencies, shall establish a process for—

“(1) determining whether individuals are medicare part C eligible individuals described in section 2301(b)(5), for purposes of part A and for purposes of chapter 25 of the Internal Revenue Code of 1986; and

“(2) determining whether individuals are wrap around eligible individuals.

Such process shall be coordinated with the enrollment process described in section 2302.

“(b) DETERMINATION OF PROJECTED INCOME.—

“(1) IN GENERAL.—In determining the amount of an individual's projected modified adjusted gross income for purposes of this subpart, the income for a year shall be projected on an annual basis based on evidence of the current (and projected) modified adjusted gross income over a period of at least 3 months, as determined under uniform, national eligibility criteria established by the Secretary.

“(2) MODIFIED ADJUSTED GROSS INCOME DEFINED.—In this title, the term ‘modified adjusted gross income’ has the meaning given such term in section 59B(e)(2) of the Internal Revenue Code of 1986.

“(c) PERIOD OF ENTITLEMENT.—

“(1) BEGINNING OF BENEFITS.—Benefits under this subpart shall be available with respect to expenses incurred for items and services furnished after the date the individual is determined to be a wrap around eligible individual.

“(2) TERMINATION OF PERIOD.—

“(A) IN GENERAL.—Subject to subparagraph (C) and subsection (e), an individual who is determined to be entitled to benefits under this subpart shall remain so entitled for a period of 12 months beginning on the date on which the determination takes effect. Such period may be extended upon the filing of an application under this subpart before the end of the 12-month period.

“(B) NOTICE OF REQUIREMENT.—The Secretary shall provide for appropriate written notice of the requirement of subparagraph (A) (relating to reapplying annually in order to continue to be entitled to benefits under this subpart) to each family a member of which is entitled to benefits under this subpart at least 60 days before the expiration of the 12-month period described in such subparagraph.

“(C) EXCEPTION.—Subparagraphs (A) and (B) shall not apply with respect to an individual whose entitlement to benefits under this subpart is based

solely on the grounds that the individual is an AFDC recipient or an SSI recipient.

“(e) REQUIREMENT TO PROVIDE NOTICE OF MATERIAL CHANGE AFFECTING ELIGIBILITY FOR BENEFITS.—

“(1) IN GENERAL.—Each individual who has been determined to be entitled to benefits under this subpart (including under section 2381(c)) and whose income or status changes so that, if the individual at such time applied for such benefits, the individual’s would no longer be entitled to such benefits, the individual is required to file a notice of such change in such manner as the Secretary specifies.

“(2) CONSTRUCTION.—Nothing in this section shall be construed as authorizing reconciliation of benefits provided with respect to deductibles and coinsurance.

“(f) NOTICE AND APPEAL.—If the Secretary determines that an individual is not entitled to benefits under this subpart—

“(1) the Secretary shall notify the individual of the determination (and an explanation of the reasons for the determination), and

“(2) the Secretary shall provide the individual with an opportunity for administrative review of such determination.

“SEC. 2385. VERIFICATION OF ELIGIBILITY.

“(a) IN GENERAL.—The Secretary, in consultation with the Secretary of the Treasury, shall provide for such verification of eligibility, including verification of income, as the Secretary deems appropriate. Such verification may be made on a sample or other basis.

“(b) MONITORING CHANGES IN STATUS.—

“(1) IN GENERAL.—The Secretary periodically shall verify, using the national enrollment verification system established under subtitle B of title IX of the Health Security Act and other means, the status of individuals who are receiving benefits under this subpart in order to identify changes of employment or other status that may affect their eligibility for such benefits.

“(2) INFORMATION ON CASH ASSISTANCE RECIPIENTS.—In order to carry out paragraph (1), the Secretary shall require States administering plans under parts A or E of title IV and the entity responsible for administering the supplemental security income program under title XVI to report to the Secretary, on a semiannual basis, such information as may be necessary to verify an individual’s status as an AFDC or SSI recipient.

“(c) TERMINATION PROCESS.—If the Secretary determines that an individual is no longer eligible for benefits under this subpart due to a change in income or status, the Secretary, after notice and opportunity for a hearing, shall terminate such benefits.

“SEC. 2386. PENALTIES FOR MISREPRESENTATION.

“Any individual that knowingly misrepresents income or family status for the purpose of obtaining benefits under this part to which the individual is not entitled is subject to a civil money penalty not to exceed \$1,000 for each such misrepresentation, or, if greater, three times the amount of the benefits obtained as a result of the misrepresentation. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under this subsection in the same manner as they apply to a penalty or proceeding under section 1128A(a).”

(b) EFFECTIVE DATE.—No wrap-around benefits are available under subpart 2 of part B of title XXIII of the Social Security Act, added by subsection (a), with respect to any items or services furnished before January 1, 1998.

SEC. 8103. REVISIONS TO THE MEDICAID PROGRAM.

(a) LIMITING COVERAGE UNDER MEDICAID.—

(1) IN GENERAL.—Title XIX is amended by redesignating section 1931 as section 1932 and by inserting after section 1930 the following new section:

“LIMITATION ON COVERAGE OF ACUTE-CARE SERVICES

“SEC. 1931. (a) IN GENERAL.—Subject to subsection (b), a State plan under this title is not required to provide medical assistance consisting of payment for acute-care services.

“(b) EXCEPTIONS.—Subsection (a) shall not apply to—

“(1) emergency care and services described in section 1903(v)(2) furnished before January 1, 2001, or

“(2) inpatient mental health services provided to individuals who are entitled to benefits under part A of title XVIII.

“(c) ACUTE-CARE SERVICES DEFINED.—In this section, the term ‘acute-care services’ means all items and services described in section 1905(a) but does not include long-term care services, including long-term institutional services, such as intermediate care facility services for the mentally retarded.

“(d) NO FFP FOR STATE MAINTENANCE-OF-EFFORT.—Payment of amounts under part 2 of subtitle B of title VIII of the Health Security Act shall not constitute medical assistance for purposes of section 1903(a).”

(2) NO FEDERAL FINANCIAL PARTICIPATION.—Section 1903(i) (42 U.S.C. 1396b(i)) is amended—

(A) by striking “or” at the end of paragraph (14),

(B) by striking the period at the end of paragraph (15) and inserting “; or”, and

(C) by inserting after paragraph (15) the following new paragraph:

“(16) with respect to medical assistance consisting of payment for items and services that a State plan is not required to provide under section 1931(a).”

(3) CONFORMING AMENDMENTS RELATING TO SECONDARY PAYER.—(A) Section 1902(a)(25)(A) (42 U.S.C. 1396a(a)(25)(A)) is amended by inserting “qualified health plans (as defined in section 2 of the Health Security Act and including medicare part C),” after “of 1974),”.

(B) Section 1903(o) (42 U.S.C. 1396b(o)) is amended by inserting “and a qualified health plan (as defined in section 2 of the Health Security Act and including medicare part C)” after “of 1974”).

(c) OTHER MEDICAID CONFORMING AMENDMENTS.—Section 1902(a)(9)(C) (42 U.S.C. 1396a(a)(9)(C)) and section 1915(a)(1)(B)(ii)(I) (42 U.S.C. 1396n(a)(1)(B)(ii)(I)) are each amended by striking “paragraphs (15) and (16) of section 1861(s)” and inserting “subsections (a) and (b) of section 1890”.

SEC. 8104. FEDERAL PAYMENT OF MEDICARE COST-SHARING FOR QUALIFIED MEDICARE BENEFICIARIES.

(a) IN GENERAL.—Title XVIII, as amended by section 3116(f), is further amended by adding at the end the following new section:

“WAIVER OF COST-SHARING FOR CERTAIN LOW-INCOME BENEFICIARIES

“SEC. 1894. (a) IN GENERAL.—Subject to subsection (c)—

“(1) QUALIFIED MEDICARE BENEFICIARIES WITH INCOME BELOW 100 PERCENT OF POVERTY LEVEL.—In the case of an individual who is determined by the Secretary to be a qualified medicare beneficiary (as defined in subsection (e)(1)), the Secretary shall waive the application of all medicare cost-sharing described in subsection (d)(1).

“(2) QUALIFIED MEDICARE BENEFICIARIES WITH INCOME BELOW 120 PERCENT OF POVERTY LEVEL.—In the case of an individual who would be such a qualified medicare beneficiary but for the fact the individual’s family income exceeds 100 percent, but is less than 120 percent, of the official poverty line (as described in subsection (e)(4)), the Secretary shall waive the application of the medicare cost-sharing described in subsection (d)(1)(A)(ii).

“(3) QUALIFIED DISABLED AND WORKING INDIVIDUALS.—In the case of an individual who is determined by the Secretary to be a qualified disabled and working individual (as defined in subsection (e)(2)), the Secretary shall waive the application of the medicare cost-sharing described in subsection (d)(1)(A)(i).

“(b) PAYMENT OF AMOUNTS WAIVED TO PROVIDERS.—In the case of items or services furnished to an individual for whom the medicare cost-sharing relating to deductibles or coinsurance is waived pursuant to this section, the Secretary shall increase the amount of payment otherwise made to the individual or entity furnishing such items or services by the amount of cost-sharing the individual would have owed with respect to such items or services but for the application of this section.

“(c) TREATMENT OF CERTAIN RESIDENTS.—Subsection (a) shall only apply to individuals who reside in a State for which the State plan for medical assistance under title XIX provided, as of January 1, 1994, for medical assistance for medicare cost-sharing available for all qualified medicare beneficiaries who are covered under subsection (a)(1).

“(d) MEDICARE COST-SHARING DEFINED.—

“(1) IN GENERAL.—In this section, the term ‘medicare cost-sharing’ means the following costs incurred with respect to a qualified medicare beneficiary or a qualified disabled and working individual:

“(A)(i) Premiums under section 1818 or 1818A, and

“(ii) premiums under section 1839.

“(B) Coinsurance under this title (including coinsurance described in section 1813).

"(C) Deductibles established under this title (including those described in section 1813, 1833(b), and 1834(b)).

"(D) The difference between the amount that is paid under section 1833(a) and the amount that would be paid under such section if any reference to '80 percent' therein were deemed a reference to '100 percent'.

"(2) ENROLLMENT WITH ELIGIBLE ORGANIZATIONS.—Under rules established by the Secretary for an individual described in subsection (a)(1), 'medicare cost-sharing' under this section may include premiums for the enrollment of the individual with an eligible organization under section 1876.

"(e) INDIVIDUALS DEFINED.—

"(1) QUALIFIED MEDICARE BENEFICIARY.—In this section, the term 'qualified medicare beneficiary' means an individual—

"(A) who is entitled to benefits under part A (other than an individual entitled to such benefits only pursuant to an enrollment under section 1818A);

"(B) whose income (as determined under section 1612 for purposes of the supplemental security income program, except as provided in paragraph (3)) does not exceed 100 percent of the official poverty line applicable to a family of the size involved; and

"(C) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program.

"(2) QUALIFIED DISABLED AND WORKING INDIVIDUAL.—The term 'qualified disabled and working individual' means an individual—

"(A) who is entitled to enroll for hospital insurance benefits under part A under section 1818A;

"(B) whose income (as determined under section 1612 for purposes of the supplemental security income program, except as provided in paragraph (3)) does not exceed 200 percent of the official poverty line applicable to a family of the size involved;

"(C) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual or a couple (in the case of an individual with a spouse) may have and obtain benefits under that program; and

"(D) who is not eligible for medical assistance under the State plan for medical assistance under title XIX for the State in which the individual resides.

"(3) EXCLUSION OF CERTAIN TRANSITION INCOME.—In determining under this subsection the income of an individual who is entitled to monthly insurance benefits under title II for a transition month in a year, such income shall not include any amounts attributable to an increase in the level of monthly insurance benefits payable under such title which have occurred pursuant to section 215(i) for benefits payable for months beginning with December of the previous year. In the previous sentence, the term 'transition month' means each month in a year through the month following the month in which the annual revision of the official poverty line (as described in paragraph (4)) is published.

"(4) OFFICIAL POVERTY LINE DESCRIBED.—In this section, the 'official poverty line' is the line defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.

"(5) USE OF ALTERNATIVE METHODOLOGIES.—

"(A) IN GENERAL.—The methodology to be employed in determining income and resource eligibility under this subsection may be less restrictive, and shall be no more restrictive, than the methodology—

"(i) in the case of groups consisting of aged, blind, or disabled individuals, under the supplemental security income program under title XVI, or

"(ii) in the case of other groups, under the State plan most closely categorically related.

"(B) MORE RESTRICTIVE METHODOLOGY DESCRIBED.—For purposes of this paragraph, a methodology is considered to be 'no more restrictive' if, using the methodology, additional individuals may be eligible for treatment as qualified medicare beneficiaries or qualified disabled and working individuals and no individuals who are otherwise eligible to be so treated are made ineligible for such treatment.

“(f) TIMING.—If an individual is determined to be a qualified medicare beneficiary or a qualified disabled and working individual under this section, such determination shall apply to items and services furnished after the end of the month in which the determination first occurs.”.

(b) CONFORMING MEDICAID AMENDMENTS.—(1) Section 1902(a)(10) (42 U.S.C. 1396a(a)(10)) is amended—

(A) in subparagraph (C) in the matter preceding clause (i), by striking “or (E)”;

(B) by adding “and” at the end of subparagraph (D);

(C) by striking subparagraph (E) and redesignating subparagraph (F) as subparagraph (E); and

(D) in the matter following subparagraph (E) (as so redesignated), by striking clause (VIII).

(2) Section 1902(e) (42 U.S.C. 1396a(e)) is amended by striking paragraph (8).

(3) The first sentence of section 1902(f) (42 U.S.C. 1396a(f)) is amended by striking “qualified disabled” and all that follows through “medicare beneficiaries”.

(3) Section 1902(m)(4) (42 U.S.C. 1396a(m)(4)) is amended—

(A) in the matter preceding subparagraph (A), by striking “1905(p)(1)” and inserting “1894(e)(1)”;

(B) in subparagraph (A), by striking “1905(p)(1)(B)” and inserting “1894(e)(1)(B)”.

(4) Section 1902(u)(2) (42 U.S.C. 1396a(u)(2)) is amended by striking “(a)(10)(F)” and inserting “(a)(10)(E)”.

(5) Section 1903(f)(4) (42 U.S.C. 1396b(f)(4)) is amended in the matter preceding subparagraph (A) by striking “1902(a)(10)(A)(ii)(X), or 1905(p)(1)” and inserting “or 1902(a)(10)(A)(ii)(X)”.

(6) Section 1905(a) (42 U.S.C. 1396d(a)) is amended in the matter preceding paragraph (1) by striking “or, in the case of medicare cost-sharing” and all that follows through “such a beneficiary”.

(7) Section 1905 (42 U.S.C. 1396d) is amended by striking subsections (p) and (s).

(8) Section 1916 (42 U.S.C. 1396o) is amended—

(A) in subsection (a) in the matter preceding paragraph (1), by striking “or (E)(i)”;

(B) in subsection (b) in the matter preceding paragraph (1), by striking “or (E)”;

(C) by striking subsection (d).

(c) CONFORMING MEDICARE AMENDMENTS.—(1) Section 1818(g)(1) (42 U.S.C. 1395i-2(g)(1)) is amended by striking “1905(p)(1)” and inserting “1894(e)(1)”.

(2) Section 1843(h) (42 U.S.C. 1395v(h)) is amended by striking “1905(p)(1)” each place it appears in paragraph (1)(B) and paragraph (2) and inserting “1894(e)(1)”

(3) Section 1848(g)(3)(A) (42 U.S.C. 1395w-4(g)(3)) is amended—

(A) by striking “(including as a qualified medicare beneficiary, as described in section 1905(p)(1))”, and

(B) by inserting “or who is eligible for benefits under section 1894” after “title XIX”.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to items or services furnished in a State on or after January 1, 1998.

PART 2—STATE MAINTENANCE OF EFFORT

Subpart A—Payments for Cash Assistance Recipients

SEC. 8111. STATE RESPONSIBILITY FOR PAYMENTS.

(a) IN GENERAL.—Subject to section 8133, each State shall provide in each year (beginning with 1998) for payment to the Secretary, to the credit of the Medicare Part C Trust Fund, of an amount equal to the State medical assistance percentage (as defined in subsection (b)) of the State maintenance of effort percentage (as defined in section 8135) for the year of the sum of the following products:

(1) AFDC PORTION.—The product of—

(A) the sum of—

(i) the AFDC, non-DSH per capita amount for the State for the year (determined under section 8112(a)(1)), and

(ii) the AFDC, DSH per capita amount for the State for the year (determined under section 8112(a)(2)); and

(B) the number of AFDC recipients residing in the State in the year (as determined under section 8114).

(2) SSI PORTION.—The product of—

(A) the sum of—

- (i) the SSI, non-DSH per capita amount for the State for the year (determined under section 8113), and
- (ii) the SSI, DSH per capita amount for the State for the year (determined under section 8113); and

(B) the number of SSI recipients residing in the State in the year (as determined under section 8114).

(b) STATE MEDICAL ASSISTANCE PERCENTAGE DEFINED.—In subsection (a), the term “State medical assistance percentage” means, for a State for a quarter in a fiscal year, 100 percent minus the Federal medical assistance percentage (as defined in section 1905(b) of the Social Security Act) for the State for the fiscal year.

(c) BENEFIT PACKAGE FOR LOW-INCOME INDIVIDUALS.—In this subtitle, the term “benefit package for low-income individuals” means the benefits, including the guaranteed national benefit package and the wrap-around benefits made available for low-income individuals under part A and subpart 2 of part B of title XXIII of the Social Security Act, as added by the previous provisions of this title.

SEC. 8112. DETERMINATION OF AFDC PER CAPITA AMOUNTS FOR STATES.

(a) DETERMINATIONS.—

(1) IN GENERAL.—For each State for each year, the Secretary shall determine an AFDC, non-DSH per capita amount in accordance with paragraph (2) and an AFDC, DSH per capita amount in accordance with paragraph (3).

(2) AFDC, NON-DSH PER CAPITA AMOUNT.—The AFDC, non-DSH per capita amount is equal to the per capita, non-DSH State medicaid expenditures (under subsection (b)(1)) for the benefit package for low-income individuals (as defined in section 8111(c)) for AFDC recipients for the State for the year (as determined under subsection (b)(1)).

(3) AFDC, DSH PER CAPITA AMOUNT.—The AFDC, DSH per capita amount is equal to the per capita DSH State medicaid expenditures (under subsection (b)(2)) for the benefit package for low-income individuals (as defined in section 8111(c)) for AFDC recipients for the State for the year (as determined under subsection (b)(2)).

(b) PER CAPITA STATE MEDICAID EXPENDITURES DEFINED.—For purposes of subsection (a)—

(1) PER CAPITA NON-DSH STATE MEDICAID EXPENDITURES.—The “per capita non-DSH State medicaid expenditures” for the benefit package for low-income individuals for a State for a year is equal to the base per capita non-DSH expenditures (described in subsection (c)(1)), updated to the year involved under subsection (d)).

(2) PER CAPITA DSH STATE MEDICAID EXPENDITURES.—The “per capita DSH State medicaid expenditures” for the benefit package for low-income individuals for a State for a year is equal to the base per capita DSH expenditures (described in subsection (c)(2)), updated to the year involved under subsection (d)).

(c) MEDICAID EXPENDITURES.—

(1) BASE PER CAPITA NON-DSH EXPENDITURES.—The “base per capita non-DSH expenditures” described in this paragraph, for a State for a year, is—

(A) the baseline non-DSH medicaid expenditures (as defined in subsection (e)(1)(A)) for the State, divided by

(B) the number of AFDC recipients enrolled in the State medicaid plan in fiscal year 1993, as determined under section 8114(a).

(2) BASE PER CAPITA DSH EXPENDITURES.—The “base per capita DSH expenditures” described in this paragraph, for a State for a year, is—

(A) the baseline DSH medicaid expenditures (as defined in subsection (e)(1)(B)) for the State; divided by

(B) the number of AFDC recipients enrolled in the State medicaid plan in fiscal year 1993, as determined under section 8114(a).

(d) UPDATING.—

(1) INITIAL UPDATE THROUGH 1997.—

(A) IN GENERAL.—

(i) BASE PER CAPITA NON-DSH EXPENDITURES.—The Secretary shall update the base per capita non-DSH expenditures described in subsection (c)(1) for each State from fiscal year 1993 through 1997, by 49.1 percent.

(ii) BASE PER CAPITA DSH EXPENDITURES.—The Secretary shall update the base per capita DSH expenditures described in subsection (c)(2) for each State from fiscal year 1993 through 1997, by 30 percent.

(B) ADJUSTMENT AUTHORIZED TO TAKE INTO ACCOUNT CASH FLOW VARIATIONS.—In determining the update under paragraph (1), the Secretary may provide for an adjustment in a manner similar to the adjustment permitted under section 8122(b)(3).

(2) UPDATE FOR SUBSEQUENT YEARS.—For each State for the 1998 and for each subsequent year the Secretary shall update the base per capita non-DSH expenditures described in subsection (c)(1) (as previously updated under this subsection) and the base per capita DSH expenditures described in subsection (c)(2) (as previously updated under this subsection) by a factor equal to the national medicare growth factor (under section 8201(c) for the year.

(e) DETERMINATION OF BASELINE MEDICAID EXPENDITURES.—

(1) IN GENERAL.—

(A) BASELINE NON-DSH MEDICAID EXPENDITURES.—For purposes of subsection (c)(1)(A), the “baseline non-DSH medicaid expenditures” for a State is the gross amount of payments under the State medicaid plan with respect to medical assistance furnished, for items and services included in the benefit package for low-income individuals, for AFDC recipients for calendar quarters in fiscal year 1993, but does not include such expenditures for which no Federal financial participation is provided under such plan and does not include any payments made under section 1923 of the Social Security Act (relating to DSH payments).

(B) BASELINE DSH MEDICAID EXPENDITURES.—For purposes of subsection (c)(2)(A), the term “baseline DSH medicaid expenditures” for a State is payments made under section 1923 of the Social Security Act in fiscal year 1993 multiplied by the proportion of payments for medical assistance for hospital services (including psychiatric hospital services) under the State medicaid plan in fiscal year 1993 that is attributable to AFDC recipients.

(2) TREATMENT OF DISALLOWANCES.—The amount determined under this subsection shall take into account amounts (or an estimate of amounts) disallowed.

(f) APPLICATION TO PARTICULAR ITEMS AND SERVICES IN BENEFIT PACKAGE FOR LOW-INCOME INDIVIDUALS.—For purposes of this section, in determining the per capita State non-DSH medicaid expenditures and the per capita State DSH medicaid expenditures for a category of items and services (within the benefit package for low-income individuals) furnished in a State, there shall be counted only that proportion of such expenditures (determined only with respect to medical assistance furnished to AFDC recipients) that were attributable to items and services included in the benefit package for low-income individuals (taking into account any limitation on amount, duration, or scope of items and services included in such package).

SEC. 8113. DETERMINATION OF SSI PER CAPITA AMOUNT FOR STATES.

For States for each year, the Secretary shall determine an SSI per capita amount in accordance with this section. Such amount shall be determined in the same manner as the AFDC per capita amount for the State is determined under section 8112 except that, for purposes of this section—

(1) any reference in such section (or in sections referred to in such section) to an “AFDC recipient” is deemed a reference to an “SSI recipient”; and

(2)(A) 75.3 percent shall be substituted for 49.1 percent in section 8112(d)(1)(A)(i), and

(B) 35.0 percent shall be substituted for 30.0 percent in section 8112(d)(1)(A)(ii).

SEC. 8114. DETERMINATION OF NUMBER OF AFDC AND SSI RECIPIENTS.

(a) BASELINE.—For purposes of section 8112 and section 8113, the number of AFDC recipients and SSI recipients for a State for fiscal year 1993 shall be determined based on actual reports submitted by the State to the Secretary. In the case of individuals who were not recipients for the entire fiscal year, the number shall take into account only the portion of the year in which they were such recipients. The Secretary may audit such reports.

(b) SUBSEQUENT YEARS.—For purposes of section 8111(a), the number of AFDC and SSI recipients residing in a State shall be determined on a monthly basis based on the actual number of such recipients.

Subpart B—Payments for Non-Cash Assistance Recipients

SEC. 8121. STATE RESPONSIBILITY FOR PAYMENTS.

(a) PAYMENT.—Each State shall provide for each year (beginning with 1998) for payment to the Secretary, to the credit of the Medicare Part C Trust Fund, of the amounts specified in subsection (b).

(b) AMOUNT.—Subject to section 8133, the total amount of such payment for a year shall be equal to the State maintenance of effort percentage (as defined in section 8135) for the year of the sum of—

(1) the State non-cash, non-DSH baseline amount for the State, determined under section 8122(a)(1) and updated to the year involved under section 8123, and

(2) the State non-cash, DSH baseline amount for the State, determined under section 8122(a)(2) and updated to the year involved under section 8123.

SEC. 8122. DETERMINATION OF BASELINE AMOUNTS.

(a) BASELINE AMOUNTS.—

(1) NON-DSH AMOUNT.—The Secretary shall determine for each State a non-cash, non-DSH baseline amount which is equal to the aggregate State medicaid expenditures in fiscal year 1993 (as defined in subsection (c)(1)) for the benefit package for low-income individuals for non-cash assistance recipients (as defined in subsection (b)).

(2) DSH AMOUNT.—The Secretary shall determine for each State a non-cash, DSH baseline amount which is equal to the DSH expenditures in fiscal year 1993 (as defined in subsection (c)(2)) multiplied by the proportion of payments for medical assistance for hospital services (including psychiatric hospital services) under the State medicaid plan in fiscal year 1993 that is attributable to non-cash assistance recipients.

(b) NON-CASH ASSISTANCE RECIPIENT.—In this part, the term “non-cash assistance recipient” means an eligible individual who is not an AFDC or SSI recipient or a medicare part A beneficiary.

(c) STATE MEDICAID EXPENDITURES AND DSH EXPENDITURES DEFINED.—

(1) AGGREGATE STATE MEDICAID EXPENDITURES.—

(A) IN GENERAL.—In this section, the term “aggregate State medicaid expenditures” means, with respect to a State in fiscal year 1993, the amount of payments under the State medicaid plan with respect to medical assistance furnished for non-cash assistance recipients for calendar quarters in fiscal year 1993, less the amount of Federal financial participation paid to the State with respect to such assistance, and not including any DSH expenditures (as defined in paragraph (2)).

(B) LIMITED TO PAYMENTS FOR SERVICES.—In applying subparagraph (A), payments under the State medicaid plan shall not be included unless Federal financial participation is provided with respect to such payments under section 1903(a)(1) of the Social Security Act and such payments shall not include payments for medicare cost-sharing (as defined in section 1905(p)(3) of the Social Security Act).

(2) DSH EXPENDITURES.—In this section, the term “DSH expenditures” means payments made under section 1923 of the Social Security Act in fiscal year 1993.

(3) ADJUSTMENT AUTHORIZED TO TAKE INTO ACCOUNT CASH FLOW VARIATIONS.—If the Secretary finds that a State took an action that had the effect of shifting the timing of medical assistance payments under the State medicaid plan between quarters or fiscal years in a manner so that the payments made in fiscal year 1993 do not accurately reflect the value of the medical assistance provided with respect to items and services furnished in that fiscal year, the Secretary may provide for such adjustment in the amounts computed under this subsection as may be necessary so that the non-cash, non-DSH baseline amount and the non-cash, DSH baseline amount determined under this section accurately reflect such value.

(4) TREATMENT OF DISALLOWANCES.—The amounts determined under this subsection shall take into account amounts (or an estimate of amounts) disallowed.

(d) APPLICATION TO PARTICULAR ITEMS AND SERVICES IN THE BENEFIT PACKAGE FOR LOW-INCOME INDIVIDUALS.—For purposes of subsection (a), in determining the aggregate State medicaid expenditures for a category of items and services (within the benefit package for low-income individuals) furnished in a State, there shall be counted only that proportion of such expenditures that were attributable to items and services included in such package (taking into account any limitation on amount, duration, or scope of items and services included in such package).

SEC. 8123. UPDATING OF BASELINE AMOUNT.

(a) UPDATE FOR YEARS THROUGH 1997.—

(1) NON-CASH, NON-DSH BASELINE AMOUNT.—The Secretary shall update the non-cash, non-DSH baseline amount determined under section 8122(a)(1) for each State for years from fiscal year 1993 through 1997 by 65.4 percent.

(2) **NON-CASH, DSH BASELINE AMOUNT.**—The Secretary shall update the non-cash, DSH baseline amount determined under section 8122(a)(2) for each State for years from fiscal year 1993 through 1997 by 33.0 percent.

(3) **ADJUSTMENT AUTHORIZED TO TAKE INTO ACCOUNT CASH FLOW VARIATIONS.**—In determining the updates under paragraph (1), the Secretary may provide for an adjustment in a manner similar to the adjustment permitted under section 8122(b)(3).

(b) **UPDATE FOR SUBSEQUENT YEARS.**—For each State for each year after 1997, the Secretary shall update the non-cash, non-DSH baseline amount (as previously updated under this section) and the non-cash, DSH baseline amount (as previously updated under this section) by the product of—

(1) 1 plus the national medicare growth factor (under section 8201(c)) for the year, and

(2) 1 plus the annual percentage increase in the population of the United States of individuals who are under 65 years of age (as estimated by the Secretary based on projections made by the Bureau of Labor Statistics of the Department of Labor) for the year.

Subpart C—General and Miscellaneous Provisions

SEC. 8131. TIMING AND MANNER OF PAYMENTS.

(a) **IN GENERAL.**—Amounts required to be paid under this part shall be paid on a periodic basis specified by the Secretary, taking into account the benefits provided under part B of title XXIII of the Social Security Act and taking into account the manner in which States provide for payments under agreements under section 1843 of such Act.

(b) **PERIODIC PROVISION OF INFORMATION.**—Each State shall periodically transmit to the Secretary such information as the Secretary may require to verify the amounts payable.

(c) **RECONCILIATION.**—

(1) **PRELIMINARY.**—At such time after the end of each year as the Secretary shall specify, the State shall submit to the Secretary such information as the Secretary may require to do a preliminary reconciliation of the amounts paid under this part and the amounts due.

(2) **FINAL.**—No later than June 30 of each year, the Secretary shall provide for a final reconciliation for such payments for quarters in the previous year. Amounts subsequently payable are subject to adjustment to reflect the results of such reconciliation.

(3) **AUDIT.**—Payments under this part are subject to audits by the Secretary in accordance with rules established by the Secretary.

SEC. 8132. SPECIAL RULES FOR PUERTO RICO AND OTHER TERRITORIES.

(a) **COMPUTATION OF BASELINES AS IF COMMONWEALTHS AND TERRITORIES WERE STATES.**—

(1) **IN GENERAL.**—For purposes of determining payment amounts by the Commonwealths and territories under subpart A and subpart B of this part, subject to paragraph (2), the Secretary, in consultation with such Commonwealths and territories and using data on expenditures reported to the Secretary by the Commonwealths and territories, shall compute—

(A) the base per capita non-DSH expenditures and base per capita DSH expenditures, under section 8112(c), and

(B) the non-cash, non-DSH baseline amount and the non-cash, DSH baseline amount, under section 8122(a), in the same manner as if the Commonwealths and territories had been one of the 50 States of the United States.

(2) **REDUCTION OF MAINTENANCE OF EFFORT PAYMENTS BY AMOUNT OF TOBACCO TAXES IN PUERTO RICO.**—The payment amounts otherwise payable under subparts A and B of this part by each of the Commonwealths and territories for a year shall be ratably reduced by ratio of—

(A) the amount of additional revenues in the year which the Secretary of the Treasury estimates to be attributable to section 5701(h) of the Internal Revenue Code of 1986 (as added by section 11101(h) of this Act), to

(B) the total payment amounts otherwise payable under such subparts by all of the Commonwealths and territories for the year.

(b) **TREATMENT OF CERTAIN SSI RECIPIENTS.**—With respect to the Commonwealths and territories insofar as they are not covered under the supplementary security income program, in this part, the term “SSI recipient” includes an individual

receiving aid under a territorial program for the aged, blind, or disabled under the Social Security Act.

(c) **COMMONWEALTHS AND TERRITORIES.**—In this section, the term “Commonwealths and territories” means Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

SEC. 8133. SANCTIONS FOR FAILURE TO MAKE TIMELY PAYMENTS.

(a) **REDUCTION OF FEDERAL MATCHING PAYMENTS.**—To the extent that a State that fails to make the payments required under this part in a timely manner, the Secretary shall withhold the required amounts from Federal matching payments that would otherwise be paid to the State for all programs administered by or through the Department of Health and Human Services.

(b) **REDUCTION OF OTHER FEDERAL PAYMENTS.**—To the extent that the amounts withheld under subsection (a) for a State is less than the total amount which a State has failed to pay under this part, the Secretary shall reduce any other payments that would otherwise be paid to the State for any program administered by or through the Department of Health and Human Services.

(c) **CONSTRUCTION.**—Nothing in this section shall be construed as affecting payments made directly to individuals, whether or not such payments are administered by a State agency.

SEC. 8134. TRANSITION RULE FOR CERTAIN STATES.

(a) **IN GENERAL.**—In the case of a State for which the first day of the first year following the close of the first regular session of the State’s legislature that begins on or after the date of the enactment of this Act is after January 1, 1998, instead of the payments otherwise required under this part, the State shall make payments to the Secretary, to the credit of the Medicare Part C Trust Fund, of an amount equal to 100 percent of the amount of the premiums under part A of title XXIII of the Social Security Act payable on behalf of each individual who is entitled to medical assistance under the State medicaid plan.

(b) **TERMINATION.**—Subsection (a) shall not apply as of the first day of the first year following the close of the first regular session of the State’s legislature that begins on or after January 1, 1998.

SEC. 8135. STATE MAINTENANCE OF EFFORT PERCENTAGE.

For purposes of sections 8111(a) and 8121(b), the term “State maintenance of effort percentage” means—

- (1) 100 percent for 1998, 1999, and 2000,
- (2) 96 percent for 2001 and 2002, and
- (3) 86 percent for each year thereafter.

Subtitle C—Cost Containment in the Medicare Programs

PART 1—MEDICARE HEALTH EXPENDITURE ESTIMATES

SEC. 8201. NATIONAL MEDICARE PER CAPITA HEALTH EXPENDITURE ESTIMATE.

(a) **ESTABLISHMENT.**—

(1) **IN GENERAL.**—For each calendar year (beginning with 1996), there is established a national medicare per capita health expenditure estimate (in this subtitle referred to as the “national medicare per capita estimate”) determined under paragraph (2).

(2) **AMOUNT.**—Subject to subsection (e)—

(A) **NATIONAL MEDICARE PER CAPITA ESTIMATE.**—

(i) **1996 AND 1997.**—The national medicare per capita estimate for 1996 and 1997 is equal to the national medicare A/B per capita estimate for the respective year.

(ii) **SUBSEQUENT YEARS.**—The national medicare per capita estimate for a year after 1997 is equal to the average, weighted by the estimated number of enrollees in the respective programs, of the national medicare A/B per capita estimate and the national medicare C per capita estimate for the year.

(B) **NATIONAL MEDICARE A/B PER CAPITA AMOUNT.**—

(i) **1996.**—The national medicare A/B per capita estimate for 1996 is equal to the medicare per capita budget baseline for 1995 (as determined under subsection (b)) multiplied by the sum of 1 plus the national medicare growth factor (specified under subsection (c)) for 1996.

(ii) SUBSEQUENT YEARS.—Subject to the special rule provided under subsection (e)(4) for 1998, the total amount of the national medicare A/B per capita estimate for each year after 1996 is equal to the national medicare A/B per capita estimate determined under this subparagraph for the previous year multiplied by the national medicare growth factor (specified under subsection (c)) for the year involved.

(C) NATIONAL MEDICARE C PER CAPITA AMOUNT.—

(i) 1998.—The Secretary shall estimate the national medicare C per capita estimate for 1998 by using the payment rates under the medicare part C program in 1998 and taking into account the average characteristics of the population expected to be enrolled in such program and their projected use of covered services (including wrap around services covered under subpart 2 of part B of title XXIII of the Social Security Act).

(ii) SUBSEQUENT YEARS.—The total amount of the national medicare C per capita estimate for each year after 1998 is equal to the national medicare C per capita estimate determined under this subparagraph for the previous year multiplied by the sum of 1 plus the national medicare growth factor (specified under subsection (c)) for the year involved.

(3) PUBLICATION.—The Secretary of Health and Human Services shall publish in the Federal Register and report to the Congress—

(A) by not later than April 1 before each year, an initial estimate of the per capita estimates under this subsection for the year; and

(B) by not later than October 1 before each year, a final determination of such per capita estimates for such year.

(b) MEDICARE PER CAPITA BUDGET BASELINE.—The Secretary shall compute a medicare per capita budget baseline under this subsection for 1995 as follows:

(1) 1993 ACTUAL EXPENDITURES.—The Secretary shall determine (on the basis of the best data available) the amount of the medicare per capita expenditures (as determined under subsection (d)) for 1993.

(2) PROJECTION FOR 1995.—The Secretary shall increase such amount by the Secretary's estimate of the percentage increase in the national medicare per capita estimate between the midpoint of 1993 and the midpoint of 1995.

(c) NATIONAL MEDICARE GROWTH FACTOR.—The national medicare growth factor under this subsection for each year is the sum (expressed as a fraction) of—

(1) the average annual percentage increase in the per capita gross domestic product (in current dollars, as published by the Secretary of Commerce) during the 5-year period ending with the second previous year; and

(2)(A) for 1996, 1.8 percentage points,

(B) for 1997, 1.4 percentage points,

(C) for 1998, 0.5 percentage points,

(D) for 1999, 0.1 percentage points, and

(E) for each year thereafter, 0 percentage points.

(d) DETERMINATION OF NATIONAL MEDICARE PER CAPITA EXPENDITURES FOR 1993.—

(1) IN GENERAL.—The Secretary shall determine for 1993 the national medicare per capita expenditures equal to—

(A) total covered health care expenditures (described in paragraph (2)), divided by

(B) the estimated average number of medicare beneficiaries in 1993 for whom such expenditures were determined.

(2) COVERED HEALTH CARE EXPENDITURES.—For purposes of paragraph (1)(A), the Secretary shall determine covered health care expenditures for 1993 as follows:

(A) DETERMINATION OF TOTAL EXPENDITURES.—The Secretary shall first determine the amount of total payments made for items and services under title XVIII of the Social Security Act (determined without regard to cost sharing) in 1993.

(B) REMOVAL OF CERTAIN EXPENDITURES NOT INCLUDED IN MEDICARE.—The amount so determined shall be decreased by the proportion of such amount that is attributable to any of the following:

(i) Medicaid beneficiaries.

(ii) Expenditures which are paid for items and services excluded from classes of services under section 8202(a)(4).

(e) ADJUSTMENTS.—

(1) IN GENERAL.—Except as provided in this subsection, the Secretary is not authorized to adjust the medicare A/B per capita estimate or the medicare C

per capita estimate under this section for a year once they are published before October of the previous year.

(2) RECOMMENDATIONS FOR CHANGES.—Except as permitted under paragraphs (3) and (4), the Secretary may submit to Congress recommendations for changes in the medicare A/B per capita estimate or the medicare C per capita estimate, but may not implement such recommendations without the approval of Congress.

(3) CORRECTION PERMITTED FOR ESTIMATION ERRORS IN MEDICARE PER CAPITA BUDGET BASELINE.—Insofar as the Secretary determines that the amounts used in estimating initially the medicare per capita budget baseline described in subsection (b) did not accurately reflect the actual amount described in subsection (b)(1) and the actual percentage increase described in subsection (b)(2), the Secretary shall adjust the national medicare per capita estimate to correct for such estimation errors.

(4) SPECIAL RULES.—

(A) MEDICARE A/B PER CAPITA ESTIMATE.—The Secretary shall adjust the national medicare A/B per capita estimate for each year (beginning with 1996) in order to reflect the changes in expenditures under parts A and B of the medicare program attributable to amendments made by subtitle B of title III or subtitle D of this title, including the addition of an outpatient prescription drug benefit.

(B) MEDICARE C PER CAPITA ESTIMATE.—The Secretary shall adjust the national medicare C per capita estimate for each year (beginning with 1999) in order to reflect the changes in expenditures under medicare part C attributable to the addition of benefits not included in the previous year.

SEC. 8202. CLASSES OF HEALTH CARE SERVICES.

(a) ESTABLISHMENT OF CLASSES.—

(1) IN GENERAL.—

(A) SPECIFIED SERVICES.—

(i) IN GENERAL.—Subject to subparagraph (B)(ii), in the case of items and services specified in a subparagraph under paragraph (2), all of the items and services described in that subparagraph shall be considered to be a “separate” class of health care services.

(ii) OVERLAPPING SERVICES.—Except as the Secretary may provide, items and services specified in a subparagraph of paragraph (2) shall be considered to be excluded from the subsequent subparagraphs of that paragraph.

(B) OTHER ITEMS AND SERVICES.—

(i) IN GENERAL.—In the case of items and services included as health care services under paragraph (3), the Secretary shall group such items and services into such class or classes of health care services as may be appropriate.

(ii) INCLUSION IN CLASSES OF SPECIFIED HEALTH CARE SERVICES.—In carrying out clause (i), the Secretary may include an item or service described in paragraph (3) within a class of services established under subparagraph (A).

(2) SPECIFIED HEALTH CARE SERVICES.—Subject to paragraph (4), the items and services specified in this paragraph are as follows:

(A) Inpatient hospital services, other than mental health services.

(B) Outpatient hospital services and ambulatory facility services (including renal dialysis facility services), other than mental health services.

(C) Diagnostic testing services (including clinical laboratory services and x-ray services).

(D) Physicians’ services and other professional medical services, other than mental health services.

(E) Home health services and hospice care.

(F) Rehabilitation services, such as physical therapy, occupational and speech therapy.

(G) Durable medical equipment and supplies.

(H) Prescription drugs and biologicals and insulin.

(I) Nursing facility services, including skilled nursing facility services and intermediate care facility services, other than mental health services.

(J) Mental health services.

(3) CLASSIFICATION OF ADDITIONAL ITEMS AND SERVICES.—Subject to paragraph (4), with respect to items and services (not described in paragraph (2)) which are included under the medicare program (including wrap around benefits under subpart 2 of part B of title XXIII of the Social Security Act), the Sec-

retary may classify them either within a class specified in paragraph (2) or within a new class established by the Secretary for such an item or service.

(4) **EXCLUSIONS.**—The following items and services shall not be considered to be health care services and shall not be included in a class of services under paragraph (1) or (3), except as provided in paragraph (5):

(A) Over-the-counter medications and medical equipment and devices.

(B) Homemaker and home health aide services and personal care services, and other services described in section 1915(c)(4)(B), section 1929(a), or section 1930(a) of the Social Security Act.

(C) Inpatient mental health services of a custodial nature.

(5) **INCLUSION OF MEDICARE SERVICES.**—Paragraph (4) shall not apply to items and services covered under the medicare program.

(b) **PUBLICATION.**—

(1) **IN GENERAL.**—The Secretary shall publish—

(A) by not later than April 1, 1995, proposed regulations defining the health care services and establishing the classes of services under this section, and

(B) by not later than October 1, 1995, final regulations defining the health care services and establishing such classes.

(2) **ITEMS INCLUDED IN REGULATIONS.**—In such regulations, the Secretary shall define—

(A) the class or classes to be established under subsection (a)(1),

(B) the services to be included within each class, and

(C) the methods and sources of data for computing, for purposes of this subtitle, the national medicare per capita estimate within the class.

(3) **CHANGES.**—

(A) **NO CHANGES AUTHORIZED.**—After the Secretary has established classes of services under paragraph (1)(B), the Secretary may not change such classes (or the services included in such classes), except in the case of services not previously classified. Any such services not previously classified shall be classified within one of the classes previously established.

(B) **RECOMMENDED CHANGES.**—If the Secretary determines that a change in the classification established under this section may be appropriate, the Secretary shall submit to the Congress a report proposing such change. The Secretary shall include in the report an explanation of—

(i) the rationale for such change, and

(ii) the impact of such change on the per capita estimates under this part and on medicare expenditures permitted for classes of services that would be affected by the change.

(4) **COMMISSION REPORTS.**—

(A) **INITIAL REPORTS.**—With respect to the establishment of classes of services under this section, each applicable Commission (as defined in subsection (c)), by not later than June 1, 1995, shall report to the Congress its comments concerning the classification proposed by the Secretary under paragraph (1)(A).

(B) **PERIODIC REPORTS.**—Each applicable Commission shall periodically report to Congress on changes in the system of classification under this section that should be made to promote the more efficient provision of medically appropriate health care services.

(c) **APPLICABLE COMMISSION DEFINED.**—In this subtitle, the term “applicable Commission” means—

(1) with respect to services included in a class of services furnished by a hospital, other institutional provider, or home health provider, the Prospective Payment Assessment Commission (established under section 1886(e)(2) of the Social Security Act);

(2) with respect to prescription drugs, biologicals, and insulin, the Prescription Drug Payment Review Commission (provided for under section 1847 of the Social Security Act, as added by section 3104 of this Act), and

(3) with respect to health care services not described in subparagraphs (A) and (B), the Physician Payment Review Commission (provided for under section 1845 of the Social Security Act).

SEC. 8203. ALLOCATION OF PER CAPITA ESTIMATES BY CLASS OF SERVICE FOR MEDICARE A/B.

(a) **ALLOCATION.**—

(1) **IN GENERAL.**—The Secretary shall allocate the medicare A/B per capita estimate under section 8201 for a year among classes of services specified under section 8202.

(2) PROPORTIONAL ALLOCATION BASED ON HISTORICAL PROJECTED EXPENDITURES.—The amount allocated to each class for a year shall be equal to the medicare A/B per capita estimate for the year multiplied by the ratio (expressed as a percentage) of—

(A) the historical projected medicare A/B expenditures for the class for the year (as determined under subsection (b)(2)), to

(B) the sum of such historical projected medicare A/B expenditures for all the classes for the year.

(3) PUBLICATION.—

(A) IN GENERAL.—The Secretary shall, in conjunction with the publication of the initial estimate and final determination of the per capita estimates under section 8201(a)(3) for a year, publish in the Federal Register and report to the Congress the allocation of the per capita estimates among the classes of services under this subsection.

(B) EXCEPTION FOR 1996.—For 1996, the Secretary shall publish and report the allocation of the medicare A/B per capita estimate among the classes of services under this subsection not later than August 1, 1995.

(b) HISTORICAL PROJECTED MEDICARE A/B EXPENDITURES.—

(1) IN GENERAL.—

(A) DETERMINATION.—For purposes of subsection (a)—

(i) FOR 1995.—The historical projected medicare A/B expenditures for a class of services for 1995 is equal to the portion of the national medicare per capita expenditures during 1993 (as determined under section 8201(d)) which is attributable to the class of services, multiplied twice by the medicare A/B trend factor (described in subparagraph (B)) for the class for 1995 and multiplied by the adjustment factor described in subparagraph (C) for 1995. In computing such portion for classes, the Secretary shall take into account the allocation of expenditures by health maintenance organizations among the different classes of services.

(ii) SUBSEQUENT YEARS.—The historical projected medicare A/B expenditures for a class of services for a year after 1995 is equal to the amount of the allocation for the class under clause (i) for the preceding year multiplied by the medicare A/B trend factor (described in subparagraph (B)) for the class for the year involved and multiplied by the adjustment factor described in subparagraph (C) for the year.

(B) MEDICARE A/B TREND FACTOR.—In subparagraph (A), subject to subparagraph (D), the “medicare A/B trend factor”, for a class of services, is 1 plus the average annual rate of increase in per capita medicare A/B expenditures for the class of services during the 5-year period ending with 1995.

(C) ADJUSTMENT FACTOR (NORMALIZATION).—The adjustment factor described in this subparagraph for a year is equal to the ratio of—

(i) the national medicare A/B per capita estimate for the year (as determined under section 8201(a)(2)(B)) or, for 1995, the medicare per capita budget baseline for 1995 (as determined under section 8201(b)(2)), to

(ii) the sum of the historical projected medicare A/B expenditures projected for all the classes for the year (determined under subparagraph (A) without regard to this subparagraph).

(D) SPECIAL RULE.—The Secretary shall adjust the projected medicare A/B expenditures for each year (beginning with 1996) in order to reflect the changes in expenditures under parts A and B of the medicare program attributable to amendments made by subtitle B of title III or subtitle D of this title, including the addition of an outpatient prescription drug benefit. Such adjustment shall be consistent with the adjustment described in section 8201(e)(4)(A).

(2) PUBLICATION OF TREND FACTORS.—The Secretary shall publish, by not later than August 1, 1995, the medicare A/B trend factors for the different classes of services.

(c) REVIEW AND CHANGES IN ALLOCATION.—

(1) IN GENERAL.—

(A) NO ADMINISTRATIVE AUTHORITY TO CHANGE.—Except as specifically provided in this paragraph, the Secretary has no authority to change the allocation or medicare A/B trend factors from the allocation and medicare A/B trend factors provided under this section.

(B) RECOMMENDED CHANGES.—Subject to subparagraph (C), if the Secretary determines that a change in the allocation of an estimate among

classes is appropriate, the Secretary shall submit to the Congress a report proposing such change. The Secretary shall include in the report an explanation of—

- (i) the rationale for such change, and
- (ii) the impact of such change on the per capita estimates permitted for classes of services that would be affected by the change.

(C) CORRECTION PERMITTED FOR ESTIMATION ERRORS.—Insofar as the Secretary determines that the amounts used in estimating initially the historical projected medicare A/B expenditures under this subsection did not accurately reflect the actual portions described in subsection (b)(1)(A)(i) or the actual medicare A/B trend factors described in subsection (b)(1)(B), the Secretary shall adjust the allocation of the medicare A/B per capita estimate among classes of services to correct for such estimation errors.

(2) COMMISSION REVIEW.—Each applicable Commission shall annually review and report to Congress, in its report submitted under section 8202(b)(4), on the effect of the medicare trend factors used in the allocation of the medicare A/B per capita estimate among classes of services. Such report shall include such recommendations for appropriate adjustments in the medicare trend factors as the applicable Commission considers appropriate to properly take into account at least—

- (A) changes in health care technology,
- (B) changes in the patterns and practices relating to health care delivery found to be appropriate,
- (C) changes in the distribution of health care services, and
- (D) the special health care needs of underserved rural and inner city populations.

SEC. 8204. ALLOCATION OF PER CAPITA ESTIMATES BY CLASS OF SERVICE FOR MEDICARE C.

(a) ALLOCATION.—

(1) IN GENERAL.—The Secretary shall allocate the medicare C per capita estimate under section 8201 for a year among classes of services specified under section 8202.

(2) PROPORTIONAL ALLOCATION BASED ON HISTORICAL PROJECTED EXPENDITURES.—The amount allocated to each class for a year shall be equal to the medicare C per capita estimate allocated for the year multiplied by the ratio (expressed as a percentage) of—

- (A) the historical projected medicare C expenditures for the class for the year (as determined under subsection (b)(2)), to
- (B) the sum of such historical projected medicare C expenditures for all the classes for the year.

(3) PUBLICATION.—The Secretary shall, in conjunction with the publication of the initial estimate and final determination of the per capita estimates under section 8201(a)(3) for a year, publish in the Federal Register and report to the Congress the allocation of the per capita estimates among the classes of services under this subsection.

(b) HISTORICAL PROJECTED MEDICARE PART C EXPENDITURES.—

(1) IN GENERAL.—

(A) DETERMINATION.—For purposes of subsection (a)—

(i) FOR 1998.—The historical projected medicare part C expenditures for a class of services for 1998 is equal to the portion of the national medicare C per capita estimate during 1998 (as determined under section 8201(a)(2)(C)) which is attributable to each class of services, as estimated by the Secretary based upon the best data available, consistent with data used in determining the applicable medicare part C premiums under section 2321 of the Social Security Act.

(ii) SUBSEQUENT YEARS.—The historical projected medicare C expenditures for a class of services for a year after 1998 is equal to the amount of the allocation for the class under clause (i) for the preceding year multiplied by the medicare C trend factor (described in subparagraph (B)) for the class for the year involved and multiplied by the adjustment factor described in subparagraph (C) for the year.

(B) MEDICARE C TREND FACTOR.—

(i) IN GENERAL.—In subparagraph (A), subject to clause (ii), the “medicare C trend factor”, for a class of services, the private trend factor for the class of services, as determined under section 6003(b)(1)(B).

(ii) MODIFICATION.—Based upon data from the medicaid program and such other data as the Secretary determines to be appropriate, the Sec-

retary may modify the trend factors described in clause (i) to reflect the rate of growth in services for the classes under medicare part C.

(C) **ADJUSTMENT FACTOR (NORMALIZATION).**—The adjustment factor described in this subparagraph for a year is equal to the ratio of—

(i) the national medicare C per capita estimate for the year (as determined under section 8201(a)(2)(C)), to

(ii) the sum of the historical projected medicare C expenditures projected for all the classes for the year (determined under subparagraph (A) without regard to this subparagraph).

(D) **SPECIAL RULE.**—The Secretary shall adjust the projected medicare C expenditures for each year (beginning with 1999) in order to reflect the changes in expenditures under medicare part C to reflect the changes in expenditures under medicare part C attributable to the addition of benefits not included in the previous year. Such adjustment shall be consistent with the adjustment described in section 8201(e)(4)(B).

(2) **PUBLICATION OF TREND FACTORS.**—The Secretary shall publish, by not later than April 1, 1997, the medicare C trend factors for the different classes of services.

(c) **REVIEW AND CHANGES IN ALLOCATION.**—

(1) **IN GENERAL.**—

(A) **NO ADMINISTRATIVE AUTHORITY TO CHANGE.**—Except as specifically provided in this paragraph, subsection (b)(1)(B)(ii), and sections 8201(e)(4)(B) and 8203(b)(1)(D), the Secretary has no authority to change the allocation or medicare C trend factors from the allocation and medicare C trend factors provided under this section.

(B) **RECOMMENDED CHANGES.**—If the Secretary determines that a change in the allocation of an estimate among classes is appropriate, the Secretary shall submit to the Congress a report proposing such change. The Secretary shall include in the report an explanation of—

(i) the rationale for such change, and

(ii) the impact of such change on the per capita estimates permitted for classes of services that would be affected by the change.

(2) **COMMISSION REVIEW.**—Each applicable Commission shall annually review and report to Congress, in its report submitted under section 8202(b)(4), on the effect of the medicare trend factors used in the allocation of the medicare C per capita estimate among classes of services. Such report shall include such recommendations for appropriate adjustments in the medicare trend factors as the applicable Commission considers appropriate to properly take into account at least—

(A) changes in health care technology,

(B) changes in the patterns and practices relating to health care delivery found to be appropriate,

(C) changes in the distribution of health care services, and

(D) the special health care needs of underserved rural and inner city populations.

SEC. 8205. COMBINED MEDICARE PER CAPITA ALLOCATIONS FOR CLASSES OF SERVICES.

(a) **FOR 1996 AND 1997.**—For 1996 and 1997, the Secretary shall compute a combined medicare per capita allocation for each class of services equal to the per capita amount allocated to the class for medicare A/B for the year under section 8203.

(b) **SUBSEQUENT YEARS.**—For each year after 1997, the Secretary shall compute a combined medicare per capita allocation for each class of services equal to the average of—

(1) the per capita amount allocated to the class for medicare A/B for the year under section 8203, and

(2) the per capita amount allocated to the class for medicare C for the year under section 8204,

weighted to reflect the relative average number of enrollees in the medicare program and in medicare part C, respectively, for the year.

SEC. 8206. COMPUTATION OF MEDICARE ANNUAL COMBINED RATE OF INCREASE FOR CLASSES OF SERVICES; APPLICATION TO MEDICARE PAYMENT RATES.

(a) **COMBINED RATES.**—

(1) **DETERMINATION.**—For each year (beginning with 1996) for services within each class of services, the Secretary shall determine a uniform percentage increase. The uniform percentage increase shall be such an increase as the Secretary determines will result in aggregate expenditures under the medicare program and medicare part C consistent with the combined medicare per capita allocation for such class for such year, as determined under section 8205.

(2) APPLICATION TO MEDICARE PAYMENT RATES.—Notwithstanding any provision of title XVIII or title XXIII of the Social Security Act, subject to section 4004(c)(1)(B), the amount of payment under such titles for items and services included in a class of services for a year (after 1995) shall be based on the amount of payment for such items and services under such titles in the previous year increased by the uniform percentage increase determined under paragraph (1) for such class of services for the year.

(b) PERCENTAGE INCREASE IN COMBINED ALLOCATION FOR CLASS OF PRESCRIPTION DRUGS.—For each year beginning after 1998, for purposes of sections 1834(d), 2111(d), and 2112(a) of the Social Security Act, the Secretary shall compute the percentage by which—

(1) the combined medicare per capita allocation for the class of services that includes prescription drugs for the year, exceeds

(2) the combined medicare per capita allocation for such class of services for the preceding year.

SEC. 8207. NATIONAL HEALTH EXPENDITURES REPORTING SYSTEM.

(a) IN GENERAL.—The Secretary shall establish a national health expenditures reporting system (in this section referred to as the “system”) for purposes of—

- (1) establishing per capita estimates,
- (2) allocating the medicare per capita estimates among classes of services,
- (3) determining medicare payment rates,
- (4) monitoring of any State cost containment and benefit management programs established by States pursuant to title IV, and
- (5) otherwise carrying out this subtitle.

(b) INFORMATION REPORTING.—

(1) ANNUAL REPORT BY PROVIDERS.—

(A) IN GENERAL.—Under the system, providers of health care services (including such providers within provider networks) shall submit (by not later than April 15 of each year, beginning with 1997) a report.

(B) CONTENTS.—Such a report shall include such information as the Secretary specifies relating to the provision of health care services in the previous year, including—

- (i) the volume and receipts for such services,
- (ii) cost and revenue data for hospitals and other institutional providers and revenue data for other providers, and
- (iii) information by class of service, type of payer, and State of residence of individual provided the services.

Information on revenues for activities not related to the provision of direct patient care, such as teaching or research or for services that are explicitly excluded from the system of national health expenditures estimates, shall be reported separately.

(C) FORM.—The report shall be submitted in such form and manner (including the use of electronic transmission) as the Secretary shall specify in regulation. Such form shall permit the reporting of information by health plans on behalf of providers who are in provider networks in the plan.

(D) USE OF REPORTING MECHANISMS.—To the maximum extent practicable and appropriate, reporting under such system shall be done through reporting mechanisms (such as uniform hospital reports provided under section 9105) and using data bases otherwise in use.

(E) USE OF SURVEYS.—The Secretary may, where appropriate, provide for the collection of information under the system through surveys of a sample of health care providers or with respect to a sample of information with respect to such providers.

(2) CONFIDENTIALITY.—Information gathered pursuant to the authority provided under this section shall not be disclosed in a manner that identifies individual providers of services.

(3) TRANSITION.—Before April 15, 1997, for purposes of this subtitle, the Secretary may use such other data collection and estimation techniques as may be appropriate for purposes described in subsection (a).

(c) ENFORCEMENT.—If a provider of health services is required, under the system under this section, to report information and refuses, after being requested by the Secretary, to provide the information required, or deliberately provides information that is false, the Secretary may impose a civil money penalty of not to exceed \$10,000 for each such refusal or provision of false information. The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply to civil money penalties under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

PART 2—STATE HEALTH EXPENDITURE ESTIMATES

SEC. 8211. STATE MEDICARE PER CAPITA HEALTH EXPENDITURE ESTIMATE.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—For each calendar year (beginning with 1996), the Secretary shall establish a State medicare per capita health expenditure estimate (in this subtitle referred to as a “State medicare per capita estimate”) for each State under paragraph (2).

(2) AMOUNT.—Subject to subsection (e), the State medicare per capita estimate for a State for a year is equal to the national medicare per capita estimate for the year, established under section 8201, multiplied by the applicable State adjustment factor (specified under subsection (b)) for the State.

(3) PUBLICATION.—The Secretary shall publish in the Federal Register and report to the Congress and to each State—

(A) by not later than April 1 before each year, an initial estimate of the State medicare per capita estimate for each State for the year; and

(B) by not later than October 1 before each year, a final determination of the State medicare per capita estimate for each State for the year.

(4) PERIODIC COMMISSION REPORTS ON STATE ESTIMATES.—Each applicable Commission shall periodically review and report to Congress on the State medicare per capita estimates established under this section. Such a report shall include such recommendations as the respective Commission deems appropriate.

(b) STATE ADJUSTMENT FACTORS.—

(1) IN GENERAL.—The Secretary shall compute a State adjustment factor for each State consistent with this subsection.

(2) BASIS FOR COMPUTATION.—Subject to adjustment under paragraphs (3) and (4), the State adjustment factor for a State shall be equal to the ratio of the State's medicare per capita expenditures (that would be computed for the State under section 8201(d) if computations under such section were made for that State rather than for the United States) to the national medicare per capita expenditures determined under such section.

(3) ADJUSTMENT TO REFLECT HEALTH CARE EXPENDITURES FOR STATE RESIDENTS.—The Secretary shall provide for an adjustment to take into account differences among States in the in-State, and out-of-State, use of services by residents and non-residents of the State, in order that the per capita amount reflects the medicare per capita health care expenditures for residents of the State for services provided anywhere in the United States.

(4) AVERAGE.—The Secretary shall establish the State adjustment factors in such a manner as assures that the population weighted average of such factors is 1.

(c) ADJUSTMENT.—

(1) IN GENERAL.—Subject to paragraph (3), the provisions of section 8201(e) shall apply to the State medicare per capita estimates under this section in the same manner as they apply to the national medicare per capita estimate.

(2) ADJUSTMENT TO CORRECT ESTIMATION ERRORS.—Insofar as the Secretary determines that the amounts used in estimating initially the State medicare per capita estimates did not accurately reflect the correct values for the factors used in computing State adjustments factors under subsection (b), the Secretary shall adjust the State medicare per capita estimates to correct for such estimation errors.

(3) ADJUSTMENTS IN 1996 and subsequent years.—

(A) ADJUSTMENT FOR CHANGES IN BENEFITS IN 1996.—In applying section 8201(e)(4) under paragraph (1), the adjustment for each State medicare per capita estimate shall be the same as the adjustment to the national medicare per capita estimate under such section.

(B) ADJUSTMENT FOR IMPLEMENTATION OF MEDICARE PART C.—The Secretary shall adjust the State medicare per capita estimates for each State for each year (beginning with 1998) to reflect variations among States in the estimated number of residents of the State who are enrolled in medicare part C for the year.

PART 3—ADMINISTRATIVE AND JUDICIAL REVIEW

SEC. 8221. LIMITATION ON ADMINISTRATIVE AND JUDICIAL REVIEW.

There shall be no administrative or judicial review of any of the following determinations:

(1) The national medicare per capita estimate and the State medicare per capita estimate for each State.

(2) Allocation of the national medicare per capita estimate or a State medicare per capita estimate to a class of health services.

Subtitle D—Additional Medicare Savings

SEC. 8301. REDUCTION IN PAYMENTS FOR INDIRECT COSTS OF MEDICAL EDUCATION.

(a) IN GENERAL.—Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended to read as follows:

“(ii) For purposes of clause (i)(II), the indirect teaching adjustment factor is equal to $c * (((1+r) \text{ to the } n\text{th power}) - 1)$, where ‘r’ is the ratio of the hospital’s full-time equivalent interns and residents to beds and ‘n’ equals .405. For discharges occurring on or after—

“(I) May 1, 1986, and before January 1, 1998, ‘c’ is equal to 1.89;

“(II) January 1, 1998, and before October 1, 1998, ‘c’ is equal to 1.68;

“(III) October 1, 1998, and before October 1, 1999, ‘c’ is equal to 1.48; and

“(IV) October 1, 1999, ‘c’ is equal to 1.28.”.

(b) NO RESTANDARDIZATION OF PAYMENT AMOUNTS REQUIRED.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended by striking “of 1985” and inserting “of 1985, but not taking into account the amendments made by section 8301(a) of the Health Security Act”.

SEC. 8302. REDUCTIONS IN DISPROPORTIONATE SHARE ADJUSTMENTS.

(a) IN GENERAL.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended—

(1) in clause (ii), by striking “The amount” and inserting “Subject to clause (ix), the amount”; and

(2) by adding at the end the following new clause:

“(ix) Notwithstanding any other provision of this subparagraph, the Secretary shall reduce the amount of any additional payment made to a hospital under this subparagraph—

“(I) for discharges occurring on or after January 1, 1998, and before October 1, 1999, by 25 percent (or, in the case of an urban hospital that has more than 100 beds and a disproportionate patient percentage equal to or greater than 30 percent or a hospital described in the second sentence of clause (v), by 10 percent); and

“(II) for discharges occurring on or after October 1, 1999 by 50 percent (or, in the case of an urban hospital that has more than 100 beds and a disproportionate patient percentage equal to or greater than 30 percent or a hospital described in the second sentence of clause (v), by 25 percent).”.

(b) RECOMMENDATIONS ON ADJUSTMENTS TO FORMULA.—

(1) RECOMMENDATIONS OF SECRETARY.—Not later than October 1, 1995, the Secretary shall submit recommendation to Congress on methods to adjust the definition of disproportionate patient percentage used to determine the amount of payment adjustments made under section 1886(d)(5)(F) of the Social Security Act to hospitals serving a significantly disproportionate number of low-income patients to take into account the provisions of this Act, including the establishment of the health insurance benefit program under part A of title XXIII of the Social Security Act and the repeal of coverage of inpatient hospital services under State plans for medical assistance under title XIX of such Act.

(2) REPORT BY PROPAC.—The Prospective Payment Assessment Commission shall review the Secretary’s report under paragraph (2) and include recommendations relating to the report in the report submitted pursuant to section 1886(e)(3) of the Social Security Act on March 1, 1996.

SEC. 8303. REDUCTIONS IN PAYMENTS FOR CAPITAL-RELATED COSTS OF INPATIENT HOSPITAL SERVICES FOR PPS HOSPITALS.

Section 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A)) is amended by adding at the end the following new sentence: “In addition to the reduction described in the preceding sentence, for discharges occurring after September 30, 1995, the Secretary shall reduce by 7.31 percent the unadjusted standard Federal capital payment rate (as described in 42 CFR 412.308(c), as in effect on the date of the enactment of the Health Security Act) and shall reduce by 10.41 percent the unadjusted hospital-specific rate (as described in 42 CFR 412.328(e)(1), as in effect on the date of the enactment of the Health Security Act).”.

SEC. 8304. LIMITATIONS ON PAYMENT FOR PHYSICIANS' SERVICES FURNISHED BY HIGH-COST HOSPITAL MEDICAL STAFFS.

(a) IN GENERAL.—

(1) **LIMITATIONS DESCRIBED.**—Part B of title XVIII, as amended by section 2103(a), is amended by inserting after section 1848 the following new section:

"LIMITATIONS ON PAYMENT FOR PHYSICIANS' SERVICES FURNISHED BY HIGH-COST HOSPITAL MEDICAL STAFFS

"SEC. 1849. (a) SERVICES SUBJECT TO REDUCTION.—

"(1) DETERMINATION OF HOSPITAL-SPECIFIC PER ADMISSION RELATIVE VALUE.—Not later than October 1 of each year (beginning with 1997), the Secretary shall determine for each hospital—

"(A) the hospital-specific per admission relative value under subsection (b)(2) for the following year; and

"(B) whether such hospital-specific relative value is projected to exceed the allowable average per admission relative value applicable to the hospital for the following year under subsection (b)(1).

"(2) REDUCTION FOR SERVICES AT HOSPITALS EXCEEDING ALLOWABLE AVERAGE PER ADMISSION RELATIVE VALUE.—If the Secretary determines (under paragraph (1)) that a medical staff's hospital-specific per admission relative value for a year (beginning with 1998) is projected to exceed the allowable average per admission relative value applicable to the medical staff for the year, the Secretary shall reduce (in accordance with subsection (c)) the amount of payment otherwise determined under this part for each physician's service furnished during the year to an inpatient of the hospital by an individual who is a member of the hospital's medical staff.

"(3) TIMING OF DETERMINATION; NOTICE TO HOSPITALS AND CARRIERS.—Not later than October 1 of each year (beginning with 1997), the Secretary shall notify the medical executive committee of each hospital (as set forth in the Standards of the Joint Commission on the Accreditation of Health Organizations) of the determinations made with respect to the medical staff under paragraph (1).

"(b) DETERMINATION OF ALLOWABLE AVERAGE PER ADMISSION RELATIVE VALUE AND HOSPITAL-SPECIFIC PER ADMISSION RELATIVE VALUES.—

"(1) ALLOWABLE AVERAGE PER ADMISSION RELATIVE VALUE.—

"(A) URBAN HOSPITALS.—In the case of a hospital located in an urban area, the allowable average per admission relative value established under this subsection for a year is equal to 125 percent (or 120 percent for years after 1999) of the median of 1996 hospital-specific per admission relative values determined under paragraph (2) for all hospital medical staffs.

"(B) RURAL HOSPITALS.—In the case of a hospital located in a rural area, the allowable average per admission relative value established under this subsection for 1998 and each succeeding year, is equal to 140 percent of the median of the 1996 hospital-specific per admission relative values determined under paragraph (2) for all hospital medical staffs.

"(2) HOSPITAL-SPECIFIC PER ADMISSION RELATIVE VALUE.—

"(A) IN GENERAL.—The hospital-specific per admission relative value projected for a hospital (other than a teaching hospital) for a calendar year, shall be equal to the average per admission relative value (as determined under section 1848(c)(2)) for physicians' services furnished to inpatients of the hospital by the hospital's medical staff (excluding interns and residents) during the second year preceding such calendar year, adjusted for variations in case-mix and disproportionate share status among hospitals (as determined by the Secretary under subparagraph (C)).

"(B) SPECIAL RULE FOR TEACHING HOSPITALS.—The hospital-specific relative value projected for a teaching hospital in a calendar year shall be equal to the sum of—

"(i) the average per admission relative value (as determined under section 1848(c)(2)) for physicians' services furnished to inpatients of the hospital by the hospital's medical staff (excluding interns and residents) during the second year preceding such calendar year; and

"(ii) the equivalent per admission relative value (as determined under section 1848(c)(2)) for physicians' services furnished to inpatients of the hospital by interns and residents of the hospital during the second year preceding such calendar year, adjusted for variations in case-mix, disproportionate share status, and teaching status among hospitals (as determined by the Secretary under subparagraph (C)). The Secretary shall determine such equivalent relative value unit per admission for

interns and residents based on the best available data for teaching hospitals and may make such adjustment in the aggregate.

“(C) ADJUSTMENT FOR TEACHING AND DISPROPORTIONATE SHARE HOSPITALS.—The Secretary shall adjust the allowable per admission relative values otherwise determined under this paragraph to take into account the needs of teaching hospitals and hospitals receiving additional payments under subparagraphs (F) and (G) of section 1886(d)(5). The adjustment for teaching status or disproportionate share shall not be less than zero.

“(c) AMOUNT OF REDUCTION.—The amount of payment otherwise made under this part for a physician’s service that is subject to a reduction under subsection (a) during a year shall be reduced 15 percent, in the case of a service furnished by a member of the medical staff of the hospital for which the Secretary determines under subsection (a)(1) that the hospital medical staff’s projected relative value per admission exceeds the allowable average per admission relative value.

“(d) RECONCILIATION OF REDUCTIONS BASED ON HOSPITAL-SPECIFIC RELATIVE VALUE PER ADMISSION WITH ACTUAL RELATIVE VALUES.—

“(1) DETERMINATION OF ACTUAL AVERAGE PER ADMISSION RELATIVE VALUE.—Not later than October 1 of each year (beginning with 1999), the Secretary shall determine the actual average per admission relative value (as determined pursuant to section 1848(c)(2)) for the physicians’ services furnished by members of a hospital’s medical staff to inpatients of the hospital during the previous year, on the basis of claims for payment for such services that are submitted to the Secretary not later than 90 days after the last day of such previous year. The actual average per admission shall be adjusted by the appropriate case-mix, disproportionate share factor, and teaching factor for the hospital medical staff (as determined by the Secretary under subsection (b)(2)(C)). Notwithstanding any other provision of this title, no payment may be made under this part for any physician’s service furnished by a member of a hospital’s medical staff to an inpatient of the hospital during a year unless the hospital submits a claim to the Secretary for payment for such service not later than 90 days after the last day of the year.

“(2) RECONCILIATION WITH REDUCTIONS TAKEN.—In the case of a hospital for which the payment amounts for physicians’ services furnished by members of the hospital’s medical staff to inpatients of the hospital were reduced under this section for a year—

“(A) if the actual average per admission relative value for such hospital’s medical staff during the year (as determined by the Secretary under paragraph (1)) did not exceed the allowable average per admission relative value applicable to the hospital’s medical staff under subsection (b)(1) for the year, the Secretary shall reimburse the fiduciary agent for the medical staff by the amount by which payments for such services were reduced for the year under subsection (c), including interest at an appropriate rate determined by the Secretary;

“(B) if the actual average per admission relative value for such hospital’s medical staff during the year is less than 15 percentage points above the allowable average per admission relative value applicable to the hospital’s medical staff under subsection (b)(1) for the year, the Secretary shall reimburse the fiduciary agent for the medical staff, as a percent of the total allowed charges for physicians’ services performed in such hospital (prior to the withhold), the difference between 15 percentage points and the actual number of percentage points that the staff exceeds the limit allowable average per admission relative value, including interest at an appropriate rate determined by the Secretary; and

“(C) if the actual average per admission relative value for such hospital’s medical staff during the year exceeded the allowable average per admission relative value applicable to the hospital’s medical staff by 15 percentage points or more, none of the withhold is paid to the fiduciary agent for the medical staff.

“(3) MEDICAL EXECUTIVE COMMITTEE OF A HOSPITAL.—Each medical executive committee of a hospital whose medical staff is projected to exceed the allowable relative value per admission for a year, shall have one year from the date of notification that such medical staff is projected to exceed the allowable relative value per admission to designate a fiduciary agent for the medical staff to receive and disburse any appropriate withhold amount made by the carrier.

“(4) ALTERNATIVE REIMBURSEMENT TO MEMBERS OF STAFF.—At the request of a fiduciary agent for the medical staff, if the fiduciary agent for the medical staff is owed the reimbursement described in paragraph (2)(B) for excess reductions in payments during a year, the Secretary shall make such reimbursement

to the members of the hospital's medical staff, on a pro-rata basis according to the proportion of physicians' services furnished to inpatients of the hospital during the year that were furnished by each member of the medical staff.

"(e) DEFINITIONS.—In this section, the following definitions apply:

"(1) MEDICAL STAFF.—An individual furnishing a physician's service is considered to be on the medical staff of a hospital—

"(A) if (in accordance with requirements for hospitals established by the Joint Commission on Accreditation of Health Organizations)—

"(i) the individual is subject to bylaws, rules, and regulations established by the hospital to provide a framework for the self-governance of medical staff activities;

"(ii) subject to such bylaws, rules, and regulations, the individual has clinical privileges granted by the hospital's governing body; and

"(iii) under such clinical privileges, the individual may provide physicians' services independently within the scope of the individual's clinical privileges, or

"(B) if such physician provides at least one service to a medicare beneficiary in such hospital.

"(2) RURAL AREA; URBAN AREA.—The terms 'rural area' and 'urban area' have the meaning given such terms under section 1886(d)(2)(D).

"(3) TEACHING HOSPITAL.—The term 'teaching hospital' means a hospital which has a teaching program approved as specified in section 1861(b)(6)."

(2) CONFORMING AMENDMENTS.—(A) Section 1833(a)(1)(N) (42 U.S.C. 1395l(a)(1)(N)) is amended by inserting "(subject to reduction under section 1849)" after "1848(a)(1)".

(B) Section 1848(a)(1)(B) (42 U.S.C. 1395w-4(a)(1)(B)) is amended by striking "this subsection," and inserting "this subsection and section 1849,".

(b) REQUIRING PHYSICIANS TO IDENTIFY HOSPITAL AT WHICH SERVICE FURNISHED.—Section 1848(g)(4)(A)(i) (42 U.S.C. 1395w-4(g)(4)(A)(i)) is amended by striking "beneficiary," and inserting "beneficiary (and, in the case of a service furnished to an inpatient of a hospital, report the hospital identification number on such claim form)".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 1998.

SEC. 8305. MEDICARE SECONDARY PAYER.

(a) EXTENSION OF DATA MATCH.—

(1) Section 1862(b)(5)(C) (42 U.S.C. 1395y(b)(5)(C)) is amended by striking clause (iii).

(2) Section 6103(l)(12) of the Internal Revenue Code of 1986 is amended by striking subparagraph (F).

(b) REPEAL OF SUNSET ON APPLICATION TO DISABLED EMPLOYEES OF EMPLOYERS WITH MORE THAN 100 EMPLOYEES.—Section 1862(b)(1)(B)(iii) (42 U.S.C. 1395y(b)(1)(B)(iii)) is amended—

(1) in the heading, by striking "SUNSET" and inserting "EFFECTIVE DATE"; and

(2) by striking " , and before October 1, 1998".

(c) PROVISIONS RELATING TO END STAGE RENAL DISEASE BENEFICIARIES.—

(1) EXTENSION OF PERIOD.—Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended in the second sentence by striking "and on or before October 1, 1998,".

(2) CLARIFICATION OF SECONDARY PAYER FOR BENEFICIARIES COVERED UNDER GROUP HEALTH PLANS.—Effective as if included in the enactment of OBRA-1993, section 1862(b)(1)(C)(i) (42 U.S.C. 1395y(b)(1)(C)(i)) is amended—

(A) by inserting "(or a member of the individual's family) who is covered under the plan by virtue of the individual's current employment status with an employer" after "an individual"; and

(B) by inserting "solely" after "this title".

(d) PENALTY FOR LATE PAYMENT.—Section 1862(b)(2)(B)(i) (42 U.S.C. 1395y(b)(2)(B)(i)) is amended by adding at the end the following: "If a primary plan fails to make such reimbursement during the 60-day period that begins on the date such notice or other information is received, the amount required to be reimbursed shall be increased by 1 percent for each month occurring after the expiration of such period and prior to the month in which the primary plans makes the reimbursement.".

SEC. 8306. IMPOSITION OF 20 PERCENT COINSURANCE ON HOME HEALTH SERVICES UNDER MEDICARE.

(a) PART A.—Section 1813(a) (42 U.S.C. 1395e(a)) is amended by adding at the end the following new paragraph:

“(5) The amount payable for a home health service furnished to an individual under this part shall be reduced by a copayment amount equal to 20 percent of the average of all the per visit costs for such service furnished under this title determined under section 1861(v)(1)(L) (as determined by the Secretary on a prospective basis for services furnished during a calendar year).”.

(b) PART B.—Section 1833(a)(2) (42 U.S.C. 1395l(a)(2)), as amended by section 2106(c)(1), is amended—

(1) in subparagraph (A), by striking “to home health services,” and by striking the comma after “opinion”;

(2) in subparagraph (E), by striking “and” at the end;

(3) in subparagraph (F), by striking the semicolon at the end and inserting “; and”; and

(4) by adding at the end the following new subparagraph:

“(G) with respect to any home health service—

“(i) the lesser of—

“(I) the reasonable cost of such service, as determined under section 1861(v), or

“(II) the customary charges with respect to such service, less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), or

“(ii) if such service is furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this clause), free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2),

less a copayment amount equal to 20 percent of the average of all per visit costs for such service furnished under this title determined under section 1861(v)(1)(L) (as determined by the Secretary on a prospective basis for services furnished during a calendar year);”.

(c) PROVIDER CHARGES.—Section 1866(a)(2)(A)(i) (42 U.S.C. 1395cc(a)(2)(A)(i)) is amended—

(1) by striking “deduction or coinsurance” and inserting “deduction, coinsurance, or copayment”; and

(2) by striking “or (a)(4)” and inserting “(a)(4), or (a)(5)”.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 1998.

SEC. 8307. HOME HEALTH COST LIMITS.

(a) REDUCTION IN UPDATE TO ROUTINE COST LIMITS.—Section 1861(v)(1)(L)(i) (42 U.S.C. 1395x(v)(1)(L)(i)) is amended—

(1) in subclause (II), by striking “or” at the end;

(2) in subclause (III), by striking “112 percent,” and inserting “and before July 1, 1996, 112 percent, or”; and

(3) by inserting after subclause (III) the following new subclause:

“(IV) July 1, 1996, 100 percent (adjusted by such amount as the Secretary determines to be necessary to preserve the savings resulting from the enactment of section 13564(a)(1) of the Omnibus Budget Reconciliation Act of 1993).”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to cost reporting periods beginning on or after July 1, 1996.

Subtitle E—Minor and Technical Medicare Amendments

PART 1—PROVISIONS RELATING TO PART A

SEC. 8401. PROVISIONS RELATING TO ADJUSTMENTS TO STANDARDIZED AMOUNTS FOR WAGES AND WAGE-RELATED COSTS.

(a) USE OF OCCUPATIONAL MIX IN GUIDELINES FOR DETERMINATION OF AREA WAGE INDEX.—

(1) IN GENERAL.—Section 1886(d)(10)(D)(i)(I) (42 U.S.C. 1395ww(d)(10)(D)(i)(I)) is amended by inserting “(to the extent the Secretary determines appropriate)” after “taking into account”.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect as if included in the enactment of OBRA-1989.

(b) CONFORMING AMENDMENTS RELATING TO GEOGRAPHIC AREA USED TO DETERMINE WAGE INDEX APPLICABLE TO HOSPITAL.—(1) Section 1886(d)(8)(C) (42 U.S.C. 1395ww(d)(8)(C)), as amended by section 13501(b)(1) of OBRA-1993, is amended—

(A) in clause (iv), by striking “paragraph (1)” and inserting “paragraph (10)”;

and

(B) by adding at the end the following new clause:

“(v) This subparagraph shall apply with respect to discharges occurring in a fiscal year only if the Secretary uses a method for making adjustments to the DRG prospective payment rate for area differences in hospital wage levels under paragraph (3)(E) for the fiscal year that is based on the use of Metropolitan Statistical Area classifications.”.

(2) Section 1886(d)(10) (42 U.S.C. 1395ww(d)(10)) is amended—

(A) in subparagraph (C)(i)(II), by striking “the area wage index applicable” and inserting “the factor used to adjust the DRG prospective payment rate for area differences in hospital wage levels that applies”; and

(B) in subparagraph (D)—

(i) by redesignating clause (ii) as clause (iii), and

(ii) by inserting after clause (i) the following new clause:

“(ii) Notwithstanding clause (i), if the Secretary uses a method for making adjustments to the DRG prospective payment rate for area differences in hospital wage levels under paragraph (3)(E) that is not based on the use of Metropolitan Statistical Area classifications, the Secretary may revise the guidelines published under clause (i) to the extent such guidelines are used to determine the appropriateness of the geographic area in which the hospital is determined to be located for purposes of making such adjustments.”.

(c) ADJUSTMENT OF LABOR AND NON-LABOR PORTIONS OF STANDARDIZED AMOUNTS.—Section 1886(d)(3)(A)(iii) (42 U.S.C. 1395ww(d)(3)(A)(iii)) is amended by adding at the end the following: “For discharges occurring on or after October 1, 1994, the Secretary shall adjust the ratio of the labor portion to non-labor portion of each average standardized amount to equal such ratio for the national average of all standardized amounts.”.

SEC. 8402. PROVISIONS RELATING TO RURAL HEALTH TRANSITION GRANT PROGRAM.

(a) ELIGIBILITY OF RURAL PRIMARY CARE HOSPITALS FOR GRANTS.—

(1) IN GENERAL.—Section 4005(e)(2) of OBRA-1987 is amended in the matter preceding subparagraph (A) by inserting “any rural primary care hospital designated by the Secretary under section 1820(i)(2) of the Social Security Act, or” after “means”.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to grants made on or after October 1, 1993.

(b) EXTENSION OF AUTHORIZATION OF APPROPRIATIONS.—Section 4005(e)(9) of OBRA-1987 is amended—

(1) by striking “1989 and” and inserting “1989,”; and

(2) by striking “1992” and inserting “1992 and \$30,000,000 for each of fiscal years 1993 through 1997”.

(c) FREQUENCY OF REQUIRED REPORTS.—Section 4008(e)(8)(B) of OBRA-1987 is amended by striking “every 6 months” and inserting “every 12 months”.

(d) USE OF GRANTS FOR TELECOMMUNICATIONS PROJECTS.—

(1) IN GENERAL.—Section 4005(e)(7) of OBRA-1987 is amended by adding at the end the following new subparagraph:

“(E) A hospital may use a grant received under this subsection to participate in a project established by the Secretary to establish telecommunications linkages between the hospital and other medical facilities in order to permit the hospital to use the medical expertise or equipment of the other facility through telecommunications techniques. In awarding grants to hospitals for this purpose, the Secretary shall take into account the need to demonstrate alternative telecommunications techniques for rural hospitals, including interactive video telecommunications, static video imaging transmitted through the telephone system, and facsimile reproductions transmitted through the telephone system.”.

(2) SET-ASIDE OF AUTHORIZATION.—Section 4005(e)(9) of OBRA-1987 is amended by adding at the end the following: “Of the amounts authorized to be appropriated during each of the fiscal years 1996 and 1997, \$2,000,000 shall be available solely for projects described in paragraph (7)(E).”.

SEC. 8403. PSYCHOLOGY SERVICES IN HOSPITALS.

Section 1861(e)(4) (42 U.S.C. 1395x(e)(4)) is amended by striking “physician,” and inserting “physician, except that a patient receiving qualified psychologist services

(as defined in subsection (ii)) may be under the care of a clinical psychologist with respect to such services to the extent permitted under State law;”.

SEC. 8404. SKILLED NURSING FACILITIES.

(a) **CONSTRUCTION OF WAGE INDEX.**—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall begin to collect data on employee compensation and paid hours of employment in skilled nursing facilities for the purpose of constructing a skilled nursing facility wage index adjustment to the routine service cost limits required under section 1888(a)(4) of the Social Security Act.

(b) **CLARIFICATION OF REPEAL OF UTILIZATION REVIEW REQUIREMENTS.**—

(1) **IN GENERAL.**—(A) Section 1814(a)(5) (42 U.S.C. 1395f(a)(5)) is amended—

(i) by striking “and with respect” and all that follows through “regulations”;

(ii) by striking “or skilled nursing facility, as the case may be”; and

(iii) by striking “or facility”.

(B) Section 1866(d) (42 U.S.C. 1395cc(d)) is amended—

(i) by striking “or skilled nursing facility”;

(ii) by striking “or facility” each place it appears;

(iii) by striking “or for post-hospital” and all that follows through “the case may be”; and

(iv) by striking “, or (in the case of)” and all that follows through “transfer agreement.”.

(2) **EFFECTIVE DATE.**—The amendments made by paragraph (1) shall take effect as if included in the enactment of OBRA-1987.

(c) **REIMBURSEMENT FOR ATYPICAL SERVICES.**—Section 1888(c) (42 U.S.C. 1395yy(c)) is amended—

(1) by striking “(c)” and inserting “(c)(1)”; and

(2) by adding at the end the following new paragraph:

“(2) The Secretary shall establish an expedited review process under which the Secretary shall respond to the request of a skilled nursing facility received on or after October 1, 1994, for an adjustment under this subsection based on the furnishing of atypical services by the facility during any cost reporting period (including the furnishing of atypical services based on the facility’s case mix) not later than 30 days after receiving the facility’s request. If the Secretary approves a facility’s request under the process, the Secretary shall adjust the amount of the payments made under this title (on a timely basis) with respect to routine service costs of extended care services furnished by the facility for each cost reporting period for which the facility demonstrates that it furnishes (or will furnish) such atypical services.”.

(d) **PAYMENT FOR SERVICES OF INDEPENDENT LABORATORIES FURNISHED TO RESIDENTS.**—

(1) **INCLUSION AS ROUTINE SERVICE COSTS OF EXTENDED CARE SERVICES.**—Section 1861(h)(6) (42 U.S.C. 1395x(h)(6)) is amended by inserting “or an independent clinical laboratory” after “by a hospital”.

(2) **REQUIRING FACILITIES TO FURNISH LABORATORY SERVICES.**—Section 1819(b)(4)(A) (42 U.S.C. 1395i-3(b)(4)(A)) is amended—

(A) by striking “and” at the end of clause (vi);

(B) by striking the period at the end of clause (vii) and inserting “; and”; and

(C) by inserting after clause (vii) the following new clause:

“(viii) clinical laboratory services necessary to meet the needs of each resident.”.

(e) **CONFORMING AMENDMENTS TO NURSING HOME REFORM.**—

(1) **SUSPENSION OF DECERTIFICATION OF NURSES AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS BASED ON EXTENDED SURVEYS.**—

(A) **IN GENERAL.**—Section 1819(f)(2)(B)(iii)(I)(b) (42 U.S.C. 1395i-3(f)(2)(B)(iii)(I)(b)) is amended by striking the semicolon and inserting the following: “, unless the survey shows that the facility is in compliance with the requirements of subsections (b), (c), and (d) of this section;”.

(B) **EFFECTIVE DATE.**—The amendment made by subparagraph (A) shall take effect as if included in the enactment of OBRA-1990.

(2) **REQUIREMENTS FOR CONSULTANTS CONDUCTING REVIEWS ON USE OF DRUGS.**—

(A) **IN GENERAL.**—Section 1819(c)(1)(D) (42 U.S.C. 1395i-3(c)(1)(D)) is amended by adding at the end the following sentence: “In determining whether such a consultant is qualified to conduct reviews under the preceding sentence, the Secretary shall take into account the needs of nursing fa-

cilities under this title to have access to the services of such a consultant on a timely basis.”.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall take effect as if included in the enactment of OBRA–1987.

(3) INCREASE IN MINIMUM AMOUNT REQUIRED FOR SEPARATE DEPOSIT OF PERSONAL FUNDS.—

(A) IN GENERAL.—Section 1819(c)(6)(B)(i) (42 U.S.C. 1395i–3(c)(6)(B)(i)) is amended by striking “\$50” and inserting “\$100”.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall take effect January 1, 1995.

(4) DUE PROCESS PROTECTIONS FOR NURSE AIDES.—

(A) PROHIBITING STATE FROM INCLUDING UNDOCUMENTED ALLEGATIONS IN NURSES AIDE REGISTRY.—Section 1819(e)(2)(B) (42 U.S.C. 1395i–3(e)(2)(B)) is amended by striking the period at the end of the first sentence and inserting the following: “, but shall not include any allegations of resident abuse or neglect or misappropriation of resident property that are not specifically documented by the State under such subsection.”.

(B) DUE PROCESS REQUIREMENTS FOR REBUTTING ALLEGATIONS.—Section 1819(g)(1)(C) (42 U.S.C. 1395i–3(g)(1)(C)) is amended by striking the second sentence and inserting the following: “The State shall, after providing the individual involved with a written notice of the allegations (including a statement of the availability of a hearing for the individual to rebut the allegations) and the opportunity for a hearing on the record, make a written finding as to the accuracy of the allegations.”.

(C) EFFECTIVE DATE.—The amendments made by this paragraph shall take effect January 1, 1995.

(f) CORRECTIONS RELATING TO SECTION 4008.—

(1) Section 1819(b)(5)(D) (42 U.S.C. 1395i–3(b)(5)(D)), as amended by section 4008(h)(1)(D) of OBRA–1990, is amended by striking the comma before “or a new competency evaluation program.”.

(2) Section 1819(b)(5)(G) (42 U.S.C. 1395i–3(b)(5)(G)) is amended by striking “or licensed or certified social worker” and inserting “licensed or certified social worker, registered respiratory therapist, or certified respiratory therapy technician”.

(3) Section 1819(f)(2)(B)(i) (42 U.S.C. 1395i–3(f)(2)(B)(i)) is amended by striking “facilities,” and inserting “facilities (subject to clause (iii)).”.

(4) Section 1819(f)(2)(B)(iii)(I)(c) (42 U.S.C. 1395i–3(f)(2)(B)(iii)(I)(c)) is amended by striking “clauses” each place it appears and inserting “clause”.

(5) Section 1819(g)(5)(B) (42 U.S.C. 1395i–3(g)(5)(B)) is amended by striking “paragraphs” and inserting “paragraph”.

(6) Section 4008(h)(1)(F)(ii) of OBRA–1990 is amended—

(A) by striking “The amendments” and inserting “(I) The amendments”;

(B) by striking “nursing facility” each place it appears and inserting “skilled nursing facility”;

(C) by redesignating subclauses (I) through (V) as items (aa) through (ee); and

(D) by adding at the end the following new subclause:

“(II) Notwithstanding subclause (I) and subject to section 1819(f)(2)(B)(iii)(I) of the Social Security Act (as amended by clause (i)), a State may approve a training and competency evaluation program or a competency evaluation program offered by or in a skilled nursing facility described in subclause (I) if, during the previous 2 years, item (aa), (bb), (cc), (dd), or (ee) of subclause (I) did not apply to the facility.”.

(7) EFFECTIVE DATE.—The amendments made by this subsection shall take effect as if included in the enactment of OBRA–1990.

SEC. 8405. NOTIFICATION OF AVAILABILITY OF HOSPICE BENEFIT.

(a) IN GENERAL.—Section 1861(ee)(2)(D) (42 U.S.C. 1395x(ee)(2)(D)) is amended by inserting “, including hospice services,” after “post-hospital services”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished on or after the first day of the first month beginning more than one year after the date of the enactment of this Act.

SEC. 8406. CLARIFYING EXPERTISE OF INDIVIDUALS TO SERVE ON THE PROSPECTIVE PAYMENT ASSESSMENT COMMISSION.

Section 1886(e)(6)(B) (42 U.S.C. 1395ww(e)(6)(B)) is amended by striking “hospital reimbursement, hospital financial management” and inserting “health facility man-

agement, reimbursement of health facilities or other providers of services which reflect the scope of the Commission's responsibilities".

SEC. 8407. AUTHORITY FOR BUDGET NEUTRAL ADJUSTMENTS FOR CHANGES IN PAYMENT AMOUNTS FOR TRANSFER CASES.

Section 1886(d)(5)(I) (42 U.S.C. 1395ww(d)(5)) is amended—

(1) by inserting "(i)" after "(I)"; and

(2) by adding at the end the following new clause:

"(ii) In making adjustments under clause (i) for transfer cases (as defined by the Secretary) in a fiscal year, the Secretary may make adjustments to each of the average standardized amounts determined under paragraph (3) to assure that the aggregate payments made under this subsection for such fiscal year are not greater or lesser than those that would have otherwise been made in such fiscal year."

SEC. 8408. HEMOPHILIA PASS-THROUGH EXTENSION.

Effective as if included in the enactment of OBRA-1993, section 6011(d) of OBRA-1989 (as amended by section 13505 of OBRA-1993) is amended by striking "September 30, 1994" and inserting "September 30, 1999".

SEC. 8409. SUB-ACUTE CARE SERVICES DEMONSTRATION PROJECT.

(a) DEMONSTRATION PROJECT.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall conduct a demonstration project during fiscal years 1996 and 1997 on the provision of sub-acute care services under part A of the medicare program in freestanding skilled nursing facilities and hospitals.

(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated \$10,000,000 for each of the fiscal years 1996 and 1997 to conduct the demonstration project under paragraph (1).

(b) REPORT.—Not later than 6 months after the conclusion of the demonstration project conducted under subsection (a), the Secretary shall submit a report to Congress on the demonstration project, and shall include in the report an evaluation of the demonstration project together with any recommendations considered appropriate by the Secretary for changes to title XVIII of the Social Security Act relating to the provision of sub-acute care services under part A of the medicare program.

SEC. 8410. PROTECTION OF STATE HOSPITAL PAYMENT PROGRAMS.

In the case of a State hospital reimbursement system that meets the requirements of section 1814(b)(3) of the Social Security Act (as of the date of the enactment of this section), no other provision of law (including any provision of title XIX of such Act) shall be construed as preventing the system from requiring that payment for services covered under the system be made in accordance with the requirements of the system.

SEC. 8410A. CLARIFICATION OF DRG PAYMENT WINDOW EXPANSION; MISCELLANEOUS AND TECHNICAL CORRECTIONS.

(a) CLARIFICATION OF DRG PAYMENT WINDOW EXPANSION.—The first sentence of section 1886(a)(4) (42 U.S.C. 1395ww(a)(4)) is amended by inserting "(or, in the case of a hospital that is not a subsection (d) hospital, during the 1 day)" after "3 days".

(b) TECHNICAL CORRECTION RELATING TO RESIDENT ASSESSMENT IN NURSING HOMES.—Section 1819(b)(3)(C)(i)(I) (42 U.S.C. 1395i-3(b)(3)(C)(i)(I)) is amended by striking "not later than" before "14 days".

(c) TECHNICAL CORRECTION RELATING TO APPLICABLE ADJUSTMENT FACTOR FOR INDIRECT MEDICAL EDUCATION ADJUSTMENT.—Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended by striking "May 1, 1986," and inserting "October 1, 1988,".

(d) MEDICARE-DEPENDENT, SMALL RURAL HOSPITALS AND SOLE COMMUNITY HOSPITALS.—

(1) MEDICARE DEPENDENT, SMALL RURAL HOSPITALS.—

(A) CLARIFICATION OF ADDITIONAL PAYMENT.—Section 1886(d)(5)(G)(ii)(I) (42 U.S.C. 1395ww(d)(5)(G)(ii)(I)), as amended by section 13501(e)(1) of OBRA-1993, is amended by striking "the first 3 12-month cost reporting periods that begin" and inserting "the 36-month period beginning with the first day of the cost reporting period that begins".

(B) CONFORMING TARGET AMOUNTS TO EXTENSION OF ADDITIONAL PAYMENTS.—Section 1886(b)(3)(D) (42 U.S.C. 1395ww(b)(3)(D)) is amended in the matter preceding clause (i) by striking "March 31, 1993" and inserting "September 30, 1994".

(2) CLARIFICATION OF UPDATES.—Section 1886(b)(3)(B)(iv)(II) (42 U.S.C. 1395ww(b)(3)(B)(iv)(II)), as added by section 13501(a)(2) of OBRA-1993, is amended by striking "(taking into account" and all that follows through "1994)"

and inserting “(adjusted to exclude any portion of a cost reporting period beginning during fiscal year 1993 for which the applicable percentage increase is determined under subparagraph (I))”.

(e) CLERICAL CORRECTIONS.—(1) Section 1814(i)(1)(C)(i) (42 U.S.C. 1395f(i)(1)(C)(i)) is amended by striking “1990” and inserting “1990.”

(2) Section 1816(f)(2)(A)(ii) (42 U.S.C. 1396h(f)(2)(A)(ii)) is amended by striking “such agency” and inserting “such agency’s”.

PART 2—PROVISIONS RELATING TO PART B

Subpart A—Physicians’ Services

SEC. 8411. DEVELOPMENT AND IMPLEMENTATION OF RESOURCE-BASED METHODOLOGY FOR PRACTICE EXPENSES.

(a) DEVELOPMENT.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall develop a methodology for implementing in 1997 a resource-based system for determining practice expense relative value units for each physicians’ service. The methodology utilized shall recognize the staff, equipment, and supplies used in the provision of various medical and surgical services in various settings.

(2) REPORT.—The Secretary shall transmit a report by July 1, 1995, on the methodology developed under paragraph (1) to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate. The report shall include a presentation of data utilized in developing the methodology and an explanation of the methodology.

(b) IMPLEMENTATION.—

(1) IN GENERAL.—Section 1848(c)(2)(C)(ii) (42 U.S.C. 1395w-4(c)(2)(C)(ii)) is amended—

(A) by inserting “for the service for years before 1997” before “equal to”,

(B) by striking the period at the end of subclause (II) and inserting a comma, and

(C) by adding after and below subclause (II) the following:

“and for years beginning with 1997 based on the relative practice expense resources involved in furnishing the service (in accordance with the transition provided in subparagraph (G)).”.

(2) TRANSITION.—Section 1848(c)(2) (42 U.S.C. 1395w-4(c)(2)) is amended by adding at the end the following new subparagraph:

“(G) TRANSITION TO RESOURCE-BASED PRACTICE EXPENSE RELATIVE VALUE UNITS.—With respect to physicians’ services furnished in years beginning with 1997, the number of practice expense relative value units applicable under subparagraph (C)(ii) shall be equal to the following:

“(i) For services furnished in 1997, the sum of—

“(I) 75 percent of the units determined under the methodology applicable under such subparagraph for years prior to 1997; and

“(II) 25 percent of the units determined under the methodology developed by the Secretary under section 8411(a)(1) of the Health Security Act.

“(ii) For services furnished in 1998, the sum of—

“(I) 50 percent of the units determined under the methodology applicable under such subparagraph for years prior to 1997; and

“(II) 50 percent of the units determined under the methodology developed by the Secretary under section 8411(a)(1) of the Health Security Act.

“(iii) For services furnished in 1999, the sum of—

“(I) 25 percent of the units determined under the methodology applicable under such subparagraph for years prior to 1997; and

“(II) 75 percent of the units determined under the methodology developed by the Secretary under section 8411(a)(1) of the Health Security Act.

“(iv) For services furnished in years beginning with 2000, 100 percent of the units determined under the methodology developed by the Secretary under section 8411(a)(1) of the Health Security Act.”.

(3) CONFORMING AMENDMENT.—Section 1848(c)(3)(C)(ii) (42 U.S.C. 1395w-4(c)(3)(C)(ii)) is amended by striking “The practice” and inserting “For years before 2000, the practice”.

(4) APPLICATION OF CERTAIN PROVISIONS.—In implementing the amendment made by paragraph (1)(C), the provisions of clauses (ii)(II) and (iii) of section 1848(c)(2)(B) of the Social Security Act shall apply in the same manner as they apply to adjustments under clause (ii)(I) of such section.

SEC. 8412. GEOGRAPHIC COST OF PRACTICE INDEX REFINEMENTS.

(a) REQUIRING CONSULTATION WITH REPRESENTATIVES OF PHYSICIANS IN REVIEWING GEOGRAPHIC ADJUSTMENT FACTORS.—Section 1848(e)(1)(C) (42 U.S.C. 1395w-4(e)(1)(C)) is amended by striking “shall review” and inserting “shall, in consultation with appropriate representatives of physicians, review”.

(b) USE OF MOST RECENT DATA IN GEOGRAPHIC ADJUSTMENT.—Section 1848(e)(1) (42 U.S.C. 1395w-4(e)(1)) is amended by adding at the end the following new subparagraph:

“(D) USE OF RECENT DATA.—In establishing indices and index values under this paragraph, the Secretary shall use the most recent data available relating to practice expenses, malpractice expenses, and physician work effort in different fee schedule areas.”.

(c) REPORT ON REVIEW PROCESS.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall study and report to the Committee on Finance of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives on—

(1) the data necessary to review and revise the indices established under section 1848(e)(1)(A) of the Social Security Act, including—

(A) the shares allocated to physicians’ work effort, practice expenses (other than malpractice expenses), and malpractice expenses;

(B) the weights assigned to the input components of such shares; and

(C) the index values assigned to such components;

(2) any limitations on the availability of data necessary to review and revise such indices at least every three years;

(3) ways of addressing such limitations, with particular attention to the development of alternative data sources for input components for which current index values are based on data collected less frequently than every three years; and

(4) the costs of developing more accurate and timely data.

SEC. 8413. EXTRA-BILLING LIMITS.

(a) ENFORCEMENT OF LIMITS.—Section 1848(g) (42 U.S.C. 1395w-4(g)), as amended by section 13517(a) of OBRA-1993, is amended—

(1) by amending paragraph (1) to read as follows:

“(1) LIMITATION ON ACTUAL CHARGES.—

“(A) IN GENERAL.—In the case of a nonparticipating physician or nonparticipating supplier or other person (as defined in section 1842(i)(2)) who does not accept payment on an assignment-related basis for a physician’s service furnished with respect to an individual enrolled under this part, the following rules apply:

“(i) APPLICATION OF LIMITING CHARGE.—No person may bill or collect an actual charge for the service in excess of the limiting charge described in paragraph (2) for such service.

“(ii) NO LIABILITY FOR EXCESS CHARGES.—No person is liable for payment of any amounts billed for the service in excess of such limiting charge.

“(iii) CORRECTION OF EXCESS CHARGES.—If such a physician, supplier, or other person bills, but does not collect, an actual charge for a service in violation of clause (i), the physician, supplier, or other person shall reduce on a timely basis the actual charge billed for the service to an amount not to exceed the limiting charge for the service.

“(iv) REFUND OF EXCESS COLLECTIONS.—If such a physician, supplier, or other person collects an actual charge for a service in violation of clause (i), the physician, supplier, or other person shall provide on a timely basis a refund to the individual charged in the amount by which the amount collected exceeded the limiting charge for the service. The amount of such a refund shall be reduced to the extent the individual has an outstanding balance owed by the individual to the physician.

“(B) SANCTIONS.—If a physician, supplier, or other person—

“(i) knowingly and willfully bills or collects for services in violation of subparagraph (A)(i) on a repeated basis, or

“(ii) fails to comply with clause (iii) or (iv) of subparagraph (A) on a timely basis,

the Secretary may apply sanctions against the physician, supplier, or other person in accordance with paragraph (2) of section 1842(j). In applying this subparagraph, paragraph (4) of such section applies in the same manner as such paragraph applies to such section and any reference in such section to a physician is deemed also to include a reference to a supplier or other person under this subparagraph.

“(C) TIMELY BASIS.—For purposes of this paragraph, a correction of a bill for an excess charge or refund of an amount with respect to a violation of subparagraph (A)(i) in the case of a service is considered to be provided ‘on a timely basis’, if the reduction or refund is made not later than 30 days after the date the physician, supplier, or other person is notified by the carrier under this part of such violation and of the requirements of subparagraph (A).”; and

(2) in paragraph (3)(B)—

(A) by inserting after the first sentence the following: “No person is liable for payment of any amounts billed for such a service in violation of the previous sentence.”, and

(B) in the last sentence, by striking “previous sentence” and inserting “first sentence”.

(b) CLARIFICATION OF MANDATORY ASSIGNMENT RULES FOR CERTAIN PRACTITIONERS.—

(1) IN GENERAL.—Section 1842(b) (42 U.S.C. 1395u(b)), as amended by section 8416(e), is amended by adding at the end the following new paragraph:

“(18)(A) Payment for any service furnished by a practitioner described in subparagraph (C) and for which payment may be made under this part on a reasonable charge or fee schedule basis may only be made under this part on an assignment-related basis.

“(B) A practitioner described in subparagraph (C) or other person may not bill (or collect any amount from) the individual or another person for any service described in subparagraph (A), except for deductible and coinsurance amounts applicable under this part. No person is liable for payment of any amounts billed for such a service in violation of the previous sentence. If a practitioner or other person knowingly and willfully bills (or collects an amount) for such a service in violation of such sentence, the Secretary may apply sanctions against the practitioner or other person in the same manner as the Secretary may apply sanctions against a physician in accordance with subsection (j)(2) in the same manner as such section applies with respect to a physician. Paragraph (4) of subsection (j) shall apply in this subparagraph in the same manner as such paragraph applies to such section.

“(C) A practitioner described in this subparagraph is any of the following:

“(i) A physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section 1861(aa)(5)).

“(ii) A certified registered nurse anesthetist (as defined in section 1861(bb)(2)).

“(iii) A certified nurse-midwife (as defined in section 1861(gg)(2)).

“(iv) A clinical social worker (as defined in section 1861(hh)(1)).

“(v) A clinical psychologist (as defined by the Secretary for purposes of section 1861(ii)).

“(D) For purposes of this paragraph, a service furnished by a practitioner described in subparagraph (C) includes any services and supplies furnished as incident to the service as would otherwise be covered under this part if furnished by a physician or as incident to a physician’s service.”.

(2) CONFORMING AMENDMENTS.—

(A) Section 1833 (42 U.S.C. 1395l) is amended—

(i) in subsection (l)(5), by striking subparagraph (B) and redesignating subparagraph (C) as subparagraph (B);

(ii) by striking subsection (p); and

(iii) in subsection (r), by striking paragraph (3) and redesignating paragraph (4) as paragraph (3).

(B) Section 1842(b)(12) (42 U.S.C. 1395u(b)(12)) is amended by striking subparagraph (C).

(c) INFORMATION ON EXTRA-BILLING LIMITS.—

(1) PART OF EXPLANATION OF MEDICARE BENEFITS.—Section 1842(h)(7) (42 U.S.C. 1395u(h)(7)) is amended—

(A) by striking “and” at the end of subparagraph (B),

(B) in subparagraph (C), by striking “shall include”,

(C) in subparagraph (C), by striking the period at the end and inserting “, and”, and

(D) by adding at the end the following new subparagraph:

“(D) in the case of services for which the billed amount exceeds the limiting charge imposed under section 1848(g), information regarding such applicable limiting charge (including information concerning the right to a refund under section 1848(g)(1)(A)(iv)).”.

(2) DETERMINATIONS BY CARRIERS.—Subparagraph (G) of section 1842(b)(3) (42 U.S.C. 1395u(b)(3)) is amended to read as follows:

“(G) will, for a service that is furnished with respect to an individual enrolled under this part, that is not paid on an assignment-related basis, and that is subject to a limiting charge under section 1848(g)—

“(i) determine, prior to making payment, whether the amount billed for such service exceeds the limiting charge applicable under section 1848(g)(2);

“(ii) notify the physician, supplier, or other person periodically (but not less often than once every 30 days) of determinations that amounts billed exceeded such applicable limiting charges; and

“(iii) provide for prompt response to inquiries of physicians, suppliers, and other persons concerning the accuracy of such limiting charges for their services;”.

(d) REPORT ON CHARGES IN EXCESS OF LIMITING CHARGE.—Section 1848(g)(6)(B) (42 U.S.C. 1395w-4(g)(6)(B)) is amended by inserting “information on the extent to which actual charges exceed limiting charges, the number and types of services involved, and the average amount of excess charges and information” after “report to the Congress”.

(e) MISCELLANEOUS AND TECHNICAL AMENDMENTS.—Section 1833(h)(5)(D) (42 U.S.C. 1395l(h)(5)(D)) is amended—

(1) by striking “paragraphs (2) and (3)” and by inserting “paragraph (2)”; and

(2) by adding at the end the following: “Paragraph (4) of such section shall apply in this subparagraph in the same manner as such paragraph applies to such section.”.

(f) EFFECTIVE DATES.—

(1) ENFORCEMENT; MISCELLANEOUS AND TECHNICAL AMENDMENTS.—The amendments made by subsections (a) and (e) shall apply to services furnished on or after the date of the enactment of this Act; except that the amendments made by subsection (a) shall not apply to services of a nonparticipating supplier or other person furnished before January 1, 1995.

(2) PRACTITIONERS.—The amendments made by subsection (b) shall apply to services furnished on or after January 1, 1995.

(3) EOMBS.—The amendments made by subsection (c)(1) shall apply to explanations of benefits provided on or after January 1, 1995.

(4) CARRIER DETERMINATIONS.—The amendments made by subsection (c)(2) shall apply to contracts as of January 1, 1995.

(5) REPORT.—The amendment made by subsection (d) shall apply to reports for years beginning with 1995.

SEC. 8414. RELATIVE VALUES FOR PEDIATRIC SERVICES.

(a) IN GENERAL.—The Secretary of Health and Human Services shall fully develop, by not later than January 1, 1995, relative values for the full range of pediatric physicians' services which are consistent with the relative values developed for other physicians' services under section 1848(c) of the Social Security Act. In developing such values, the Secretary shall conduct such refinements as may be necessary to produce appropriate estimates for such relative values.

(b) STUDY.—

(1) IN GENERAL.—The Secretary shall conduct a study of the relative values for pediatric and other services to determine whether there are significant variations in the resources used in providing similar services to different populations. In conducting such study, the Secretary shall consult with appropriate organizations representing pediatricians and other physicians and physical and occupational therapists.

(2) REPORT.—Not later than July 1, 1995, the Secretary shall submit to Congress a report on the study conducted under paragraph (1). Such report shall include any appropriate recommendations regarding needed changes in coding or other payment policies to ensure that payments for pediatric services appropriately reflect the resources required to provide these services.

SEC. 8415. ADMINISTRATION OF CLAIMS RELATING TO PHYSICIANS' SERVICES.

(a) LIMITATION ON CARRIER USER FEES.—Section 1842(c) (42 U.S.C. 1395u(c)) is amended by adding at the end the following new paragraph:

“(4) Neither a carrier nor the Secretary may impose a fee under this title—

“(A) for the filing of claims related to physicians' services,

“(B) for an error in filing a claim relating to physicians’ services or for such a claim which is denied,

“(C) for any appeal under this title with respect to physicians’ services,

“(D) for applying for (or obtaining) a unique identifier under subsection (r),
or

“(E) for responding to inquiries respecting physicians’ services or for providing information with respect to medical review of such services.”.

(b) CLARIFICATION OF PERMISSIBLE SUBSTITUTE BILLING ARRANGEMENTS.—

(1) IN GENERAL.—Clause (D) of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended to read as follows: “(D) payment may be made to a physician for physicians’ services (and services furnished incident to such services) furnished by a second physician to patients of the first physician if (i) the first physician is unavailable to provide the services; (ii) the services are furnished pursuant to an arrangement between the two physicians that (I) is informal and reciprocal, or (II) involves per diem or other fee-for-time compensation for such services; (iii) the services are not provided by the second physician over a continuous period of more than 60 days; and (iv) the claim form submitted to the carrier for such services includes the second physician’s unique identifier (provided under the system established under subsection (r)) and indicates that the claim meets the requirements of this subparagraph for payment to the first physician”.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to services furnished on or after the first day of the first month beginning more than 60 days after the date of the enactment of this Act.

SEC. 8416. MISCELLANEOUS AND TECHNICAL CORRECTIONS.

(a) OVERVALUED PROCEDURES.—(1) Section 1842(b)(16)(B)(iii) (42 U.S.C. 1395u(b)(16)(B)(iii)) is amended—

(A) by striking “, simple and subcutaneous”,

(B) by striking “, small” and inserting “and small”,

(C) by striking “treatments;” the first place it appears and inserting “and”,

(D) by striking “lobectomy;”,

(E) by striking “enterectomy; colectomy; cholecystectomy;”,

(F) by striking “; transurethral resection” and inserting “and resection”, and

(G) by striking “sacral laminectomy;”.

(2) Section 4101(b)(2) of OBRA-1990 is amended—

(A) in the matter before subparagraph (A), by striking “1842(b)(16)” and inserting “1842(b)(16)(B)”, and

(B) in subparagraph (B)—

(i) by striking “, simple and subcutaneous”,

(ii) by striking “(HCPCS codes 19160 and 19162)” and inserting “(HCPCS code 19160)”, and

(iii) by striking all that follows “(HCPCS codes 92250” and inserting “and 92260)”.

(b) RADIOLOGY SERVICES.—(1) Section 1834(b)(4) (42 U.S.C. 1395m(b)(4)) is amended by redesignating the subparagraphs (E) and (F) redesignated by section 4102(a)(1) of OBRA-1990 as subparagraphs (F) and (G), respectively.

(2) Section 1834(b)(4)(D) (42 U.S.C. 1395m(b)(4)(D)) is amended—

(A) in the matter before clause (i), by striking “shall be determined as follows:” and inserting “shall, subject to clause (vii), be reduced to the adjusted conversion factor for the locality determined as follows:”,

(B) in clause (iv), by striking “LOCAL ADJUSTMENT.—Subject to clause (vii), the conversion factor to be applied to” and inserting “ADJUSTED CONVERSION FACTOR.—The adjusted conversion factor for”,

(C) in clause (vii), by striking “under this subparagraph”, and

(D) in clause (vii), by inserting “reduced under this subparagraph by” after “shall not be”.

(3) Section 4102(c)(2) of OBRA-1990 is amended by striking “radiology services” and all that follows and inserting “nuclear medicine services.”.

(4) Section 4102(d) of OBRA-1990 is amended by striking “new paragraph” and inserting “new subparagraph”.

(5) Section 1834(b)(4)(E) (42 U.S.C. 1395m(b)(4)(E)) is amended by inserting “RULE FOR CERTAIN SCANNING SERVICES.—” after “(E)”.

(6) Section 1848(a)(2)(D)(iii) (42 U.S.C. 1395w-4(a)(2)(D)(iii)) is amended by striking “that are subject to section 6105(b) of the Omnibus Budget Reconciliation Act of 1989” and by striking “provided under such section” and inserting “provided under section 6105(b) of the Omnibus Budget Reconciliation Act of 1989”.

(c) **ANESTHESIA SERVICES.**—(1) Section 4103(a) of OBRA-1990 is amended by striking “REDUCTION IN FEE SCHEDULE” and inserting “REDUCTION IN PREVAILING CHARGES”.

(2) Section 1842(q)(1)(B) (42 U.S.C. 1395u(q)(1)(B)) is amended—

(A) in the matter before clause (i), by striking “shall be determined as follows.” and inserting “shall, subject to clause (iv), be reduced to the adjusted prevailing charge conversion factor for the locality determined as follows.”; and

(B) in clause (iii), by striking “Subject to clause (iv), the prevailing charge conversion factor to be applied in” and inserting “The adjusted prevailing charge conversion factor for”.

(d) **ASSISTANTS AT SURGERY.**—(1) Section 4107(c) of OBRA-1990 is amended by inserting “(a)(1)” after “subsection”.

(2) Section 4107(a)(2) of OBRA-1990 is amended by adding at the end the following: “In applying section 1848(g)(2)(D) of the Social Security Act for services of an assistant-at-surgery furnished during 1991, the recognized payment amount shall not exceed the maximum amount specified under section 1848(i)(2)(A) of such Act (as applied under this paragraph in such year).”.

(e) **TECHNICAL COMPONENTS OF DIAGNOSTIC SERVICES.**—Section 1842(b) (42 U.S.C. 1395u(b)) is amended by redesignating paragraph (18), as added by section 4108(a) of OBRA-1990, as paragraph (17) and, in such paragraph, by inserting “, tests specified in paragraph (14)(C)(i),” after “diagnostic laboratory tests”.

(f) **STATEWIDE FEE SCHEDULES.**—Section 4117 of OBRA-1990 is amended—

(1) in subsection (a)—

(A) by striking “(a) IN GENERAL.—”, and

(B) by striking “, if the” and all that follows through “1991.”; and

(2) by striking subsections (b), (c), and (d).

(g) **STUDY OF AGGREGATION RULE FOR CLAIMS OF SIMILAR PHYSICIAN SERVICES.**—Section 4113 of OBRA-1990 is amended—

(1) by inserting “of the Social Security Act” after “1869(b)(2)”; and

(2) by striking “December 31, 1992” and inserting “December 31, 1993”.

(h) **OTHER MISCELLANEOUS AND TECHNICAL AMENDMENTS.**—(1) The heading of section 1834(f) (42 U.S.C. 1395m(f)) is amended by striking “FISCAL YEAR”.

(2)(A) Section 4105(b) of OBRA-1990 is amended—

(i) in paragraph (2), by striking “amendments” and inserting “amendment”, and

(ii) in paragraph (3), by striking “amendments made by paragraphs (1) and (2)” and inserting “amendment made by paragraph (1)”.

(B) Section 1848(f)(2)(C) (42 U.S.C. 1395w-4(f)(2)(C)) is amended by inserting “PERFORMANCE STANDARD RATES OF INCREASE FOR FISCAL YEAR 1991.—” after “(C)”.

(C) Section 4105(d) of OBRA-1990 is amended by inserting “PUBLICATION OF PERFORMANCE STANDARD RATES.—” after “(d)”.

(3) Section 4106(c) of OBRA-1990 is amended by inserting “of the Social Security Act” after “1848(d)(1)(B)”.

(4) Section 4114 of OBRA-1990 is amended by striking “patients” the second place it appears.

(5) Section 1848(e)(1)(C) (42 U.S.C. 1395w-4(e)(1)(C)) is amended by inserting “date of the” after “since the”.

(6) Section 4118(f)(1)(D) of OBRA-1990 is amended by striking “is amended”.

(7) Section 4118(f)(1)(N)(ii) of OBRA-1990 is amended by striking “subsection (f)(5)(A)” and inserting “subsection (f)(5)(A))”.

(8) Section 1845(e) (42 U.S.C. 1395w-1(e)) is amended—

(A) by striking paragraph (2); and

(B) by redesignating paragraphs (3), (4), and (5) as paragraphs (2), (3), and (4).

(9) Section 4118(j)(2) of OBRA-1990 is amended by striking “In section” and inserting “Section”.

(10)(A) Section 1848(i)(3) (42 U.S.C. 1395w-4(i)(3)) is amended by striking the space before the period at the end.

(B) Section 1834(a)(10)(B) (42 U.S.C. 1395m(a)(10)(B)) is amended—

(i) by striking “apply to” and inserting “would otherwise apply to”, and

(ii) by inserting before the period at the end “but for the application of section 1848(i)(3)”.

(i) **OTHER CORRECTIONS.**—(1) Effective on the date of the enactment of this Act, section 6102(d)(4) of OBRA-1989 is amended by striking all that follows the first sentence.

(2) Effective for payments for fiscal years beginning with fiscal year 1994, section 1842(c)(1) (42 U.S.C. 1395u(c)(1)) is amended—

(A) in subparagraph (A), by striking “(A) Any contract” and inserting “Any contract”; and

(B) by striking subparagraph (B).

(j) EFFECTIVE DATE.—Except as provided in subsection (i), the amendments made by this section and the provisions of this section shall take effect as if included in the enactment of OBRA-1990.

Subpart B—Durable Medical Equipment

SEC. 8421. CERTIFICATION OF SUPPLIERS.

(a) REQUIREMENTS.—

(1) IN GENERAL.—Section 1834 (42 U.S.C. 1395m), as amended by section 13544(b)(1) of OBRA-1993, is amended by adding at the end the following new subsection:

“(j) REQUIREMENTS FOR SUPPLIERS OF MEDICAL EQUIPMENT AND SUPPLIES.—

“(1) ISSUANCE AND RENEWAL OF SUPPLIER NUMBER.—

“(A) PAYMENT.—Except as provided in subparagraph (C), no payment may be made under this part after the expiration of the 60-day period that begins on the date of the enactment of the Health Security Act, for items furnished by a supplier of medical equipment and supplies unless such supplier obtains (and renews at such intervals as the Secretary may require) a supplier number.

“(B) STANDARDS FOR POSSESSING A SUPPLIER NUMBER.—A supplier may not obtain a supplier number unless—

“(i) for medical equipment and supplies furnished on or after the expiration of the 60-day period that begins on the date of the enactment of the Health Security Act, and before January 1, 1996, the supplier meets standards prescribed by the Secretary in regulations issued on June 18, 1992; and

“(ii) for medical equipment and supplies furnished on or after January 1, 1996, the supplier meets revised standards prescribed by the Secretary (in consultation with representatives of suppliers of medical equipment and supplies, carriers, and consumers) that shall include requirements that the supplier—

“(I) comply with all applicable State and Federal licensure and regulatory requirements;

“(II) maintain a physical facility on an appropriate site;

“(III) have proof of appropriate liability insurance; and

“(IV) meet such other requirements as the Secretary may specify.

“(C) EXCEPTION FOR ITEMS FURNISHED AS INCIDENT TO A PHYSICIAN'S SERVICE.—Subparagraph (A) shall not apply with respect to medical equipment and supplies furnished incident to a physician's service.

“(D) PROHIBITION AGAINST MULTIPLE SUPPLIER NUMBERS.—The Secretary may not issue more than one supplier number to any supplier of medical equipment and supplies unless the issuance of more than one number is appropriate to identify subsidiary or regional entities under the supplier's ownership or control.

“(E) PROHIBITION AGAINST DELEGATION OF SUPPLIER DETERMINATIONS.—The Secretary may not delegate (other than by contract under section 1842) the responsibility to determine whether suppliers meet the standards necessary to obtain a supplier number.

“(2) CERTIFICATES OF MEDICAL NECESSITY.—

“(A) LIMITATION ON INFORMATION PROVIDED BY SUPPLIERS ON CERTIFICATES OF MEDICAL NECESSITY.—

“(i) IN GENERAL.—Effective upon the expiration of the 60-day period that begins on the date of the enactment of the Health Security Act, a supplier of medical equipment and supplies may distribute to physicians, or to individuals entitled to benefits under this part, a certificate of medical necessity for commercial purposes which contains no more than the following information completed by the supplier:

“(I) An identification of the supplier and the beneficiary to whom such medical equipment and supplies are furnished.

“(II) A description of such medical equipment and supplies.

“(III) Any product code identifying such medical equipment and supplies.

“(IV) Any other administrative information (other than information relating to the beneficiary’s medical condition) identified by the Secretary.

“(ii) INFORMATION ON PAYMENT AMOUNT AND CHARGES.—If a supplier distributes a certificate of medical necessity containing any of the information permitted to be supplied under clause (i), the supplier shall also list on the certificate of medical necessity the fee schedule amount and the supplier’s charge for the medical equipment or supplies being furnished prior to distribution of such certificate to the physician.

“(iii) PENALTY.—Any supplier of medical equipment and supplies who knowingly and willfully distributes a certificate of medical necessity in violation of clause (i) or fails to provide the information required under clause (ii) is subject to a civil money penalty in an amount not to exceed \$1,000 for each such certificate of medical necessity so distributed. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under this subparagraph in the same manner as they apply to a penalty or proceeding under section 1128A(a).

“(B) DEFINITION.—For purposes of this paragraph, the term ‘certificate of medical necessity’ means a form or other document containing information required by the carrier to be submitted to show that an item is reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

“(3) DEFINITION.—The term ‘medical equipment and supplies’ means—

“(A) durable medical equipment (as defined in section 1861(n));

“(B) prosthetic devices (as described in section 1861(s)(8));

“(C) orthotics and prosthetics (as described in section 1861(s)(9));

“(D) surgical dressings (as described in section 1861(s)(5));

“(E) such other items as the Secretary may determine; and

“(F) for purposes of paragraph (1)—

“(i) home dialysis supplies and equipment (as described in section 1861(s)(2)(F)),

“(ii) immunosuppressive drugs (as described in section 1861(s)(2)(J)),

“(iii) therapeutic shoes for diabetics (as described in section 1861(s)(12)),

“(iv) oral drugs prescribed for use as an anticancer therapeutic agent (as described in section 1861(s)(2)(Q)), and

“(v) self-administered erythropoietin (as described in section 1861(s)(2)(P)).”

(2) CONFORMING AMENDMENT.—Section 1834(a) (42 U.S.C. 1395m(a)) is amended by striking paragraph (16).

(b) USE OF COVERED ITEMS BY DISABLED BENEFICIARIES.—

(1) IN GENERAL.—The Secretary of Health and Human Services, in consultation with representatives of suppliers of durable medical equipment under part B of the medicare program and individuals entitled to benefits under such program on the basis of disability, shall conduct a study of the effects of the methodology for determining payments for items of such equipment under such part on the ability of such individuals to obtain items of such equipment, including customized items.

(2) REPORT.—Not later than one year after the date of the enactment of this Act, the Secretary shall submit a report to Congress on the study conducted under paragraph (1), and shall include in the report such recommendations as the Secretary considers appropriate to assure that disabled medicare beneficiaries have access to items of durable medical equipment.

(c) CRITERIA FOR TREATMENT OF ITEMS AS PROSTHETIC DEVICES OR ORTHOTICS AND PROSTHETICS.—Not later than one year after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit a report to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate describing prosthetic devices or orthotics and prosthetics covered under part B of the medicare program that do not require individualized or custom fitting and adjustment to be used by a patient. Such report shall include recommendations for an appropriate methodology for determining the amount of payment for such items under such program.

SEC. 8422. RESTRICTIONS ON CERTAIN MARKETING AND SALES ACTIVITIES.

(a) PROHIBITING UNSOLICITED TELEPHONE CONTACTS FROM SUPPLIERS OF DURABLE MEDICAL EQUIPMENT TO MEDICARE BENEFICIARIES.—

(1) IN GENERAL.—Section 1834(a) (42 U.S.C. 1395m(a)) is amended by adding at the end the following new paragraph:

“(17) PROHIBITION AGAINST UNSOLICITED TELEPHONE CONTACTS BY SUPPLIERS.—

“(A) IN GENERAL.—A supplier of a covered item under this subsection may not contact an individual enrolled under this part by telephone regarding the furnishing of a covered item to the individual unless 1 of the following applies:

“(i) The individual has given written permission to the supplier to make contact by telephone regarding the furnishing of a covered item.

“(ii) The supplier has furnished a covered item to the individual and the supplier is contacting the individual only regarding the furnishing of such covered item.

“(iii) If the contact is regarding the furnishing of a covered item other than a covered item already furnished to the individual, the supplier has furnished at least 1 covered item to the individual during the 15-month period preceding the date on which the supplier makes such contact.

“(B) PROHIBITING PAYMENT FOR ITEMS FURNISHED SUBSEQUENT TO UNSOLICITED CONTACTS.—If a supplier knowingly contacts an individual in violation of subparagraph (A), no payment may be made under this part for any item subsequently furnished to the individual by the supplier.

“(C) EXCLUSION FROM PROGRAM FOR SUPPLIERS ENGAGING IN PATTERN OF UNSOLICITED CONTACTS.—If a supplier knowingly contacts individuals in violation of subparagraph (A) to such an extent that the supplier’s conduct establishes a pattern of contacts in violation of such subparagraph, the Secretary shall exclude the supplier from participation in the programs under this Act, in accordance with the procedures set forth in subsections (c), (f), and (g) of section 1128.”.

(2) REQUIRING REFUND OF AMOUNTS COLLECTED FOR DISALLOWED ITEMS.—Section 1834(a) (42 U.S.C. 1395m(a)), as amended by paragraph (1), is amended by adding at the end the following new paragraph:

“(18) REFUND OF AMOUNTS COLLECTED FOR CERTAIN DISALLOWED ITEMS.—

“(A) IN GENERAL.—If a nonparticipating supplier furnishes to an individual enrolled under this part a covered item for which no payment may be made under this part by reason of paragraph (17)(B), the supplier shall refund on a timely basis to the patient (and shall be liable to the patient for) any amounts collected from the patient for the item, unless—

“(i) the supplier establishes that the supplier did not know and could not reasonably have been expected to know that payment may not be made for the item by reason of paragraph (17)(B), or

“(ii) before the item was furnished, the patient was informed that payment under this part may not be made for that item and the patient has agreed to pay for that item.

“(B) SANCTIONS.—If a supplier knowingly and willfully fails to make refunds in violation of subparagraph (A), the Secretary may apply sanctions against the supplier in accordance with section 1842(j)(2).

“(C) NOTICE.—Each carrier with a contract in effect under this part with respect to suppliers of covered items shall send any notice of denial of payment for covered items by reason of paragraph (17)(B) and for which payment is not requested on an assignment-related basis to the supplier and the patient involved.

“(D) TIMELY BASIS DEFINED.—A refund under subparagraph (A) is considered to be on a timely basis only if—

“(i) in the case of a supplier who does not request reconsideration or seek appeal on a timely basis, the refund is made within 30 days after the date the supplier receives a denial notice under subparagraph (C), or

“(ii) in the case in which such a reconsideration or appeal is taken, the refund is made within 15 days after the date the supplier receives notice of an adverse determination on reconsideration or appeal.”.

(b) CONFORMING AMENDMENT.—Section 1834(h)(3) (42 U.S.C. 1395m(h)(3)) is amended by striking “Paragraph (12)” and inserting “Paragraphs (12) and (17)”.

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply to items furnished after the expiration of the 60-day period that begins on the date of the enactment of this Act.

SEC. 8423. BENEFICIARY LIABILITY FOR NONCOVERED SERVICES.

(a) UNASSIGNED CLAIMS.—Section 1834(j) (42 U.S.C. 1395m(i)), as added by section 8421(a)(1), is amended—

(A) by redesignating paragraph (3) as paragraph (4), and

(B) by inserting after paragraph (2) the following new paragraph:

“(3) LIMITATION ON PATIENT LIABILITY.—If a supplier of medical equipment and supplies (as defined in paragraph (4))—

“(A) furnishes an item or service to a beneficiary for which no payment may be made by reason of paragraph (1);

“(B) furnishes an item or service to a beneficiary for which payment is denied in advance under subsection (a)(15); or

“(C) furnishes an item or service to a beneficiary for which payment is denied under section 1862(a)(1);

any expenses incurred for items and services furnished to an individual by such a supplier not on an assigned basis shall be the responsibility of such supplier. The individual shall have no financial responsibility for such expenses and the supplier shall refund on a timely basis to the individual (and shall be liable to the individual for) any amounts collected from the individual for such items or services. The provisions of subsection (a)(18) shall apply to refunds required under the previous sentence in the same manner as such provisions apply to refunds under such subsection.”.

(b) ASSIGNED CLAIMS.—Section 1879 (42 U.S.C. 1395pp) is amended by adding at the end the following new subsection:

“(h) If a supplier of medical equipment and supplies (as defined in section 1834(j)(4))—

“(1) furnishes an item or service to a beneficiary for which no payment may be made by reason of section 1834(j)(1);

“(2) furnishes an item or service to a beneficiary for which payment is denied in advance under section 1834(a)(15); or

“(3) furnishes an item or service to a beneficiary for which no payment may be made by reason of section 1834(a)(17)(B),

any expenses incurred for items and services furnished to an individual by such a supplier on an assignment-related basis shall be the responsibility of such supplier. The individual shall have no financial responsibility for such expenses and the supplier shall refund on a timely basis to the individual (and shall be liable to the individual for) any amounts collected from the individual for such items or services. The provisions of section 1834(a)(18) shall apply to refunds required under the previous sentence in the same manner as such provisions apply to refunds under such section.”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items or services furnished on or after the expiration of the 60-day period that begins on the date of the enactment of this Act.

SEC. 8424. ADJUSTMENTS FOR INHERENT REASONABLENESS.

(a) ADJUSTMENTS MADE TO FINAL PAYMENT AMOUNTS.—

(1) IN GENERAL.—Section 1834(a)(10)(B) (42 U.S.C. 1395m(a)(10)(B)) is amended by adding at the end the following: “In applying such provisions to payments for an item under this subsection, the Secretary shall make adjustments to the payment basis for the item described in paragraph (1)(B) if the Secretary determines (in accordance with such provisions and on the basis of prices and costs applicable at the time the item is furnished) that such payment basis is not inherently reasonable.”.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

(b) ADJUSTMENT REQUIRED FOR CERTAIN ITEMS.—

(1) IN GENERAL.—In accordance with section 1834(a)(10)(B) of the Social Security Act (as amended by subsection (a)), the Secretary of Health and Human Services shall determine whether the payment amounts for the items described in paragraph (2) are not inherently reasonable, and shall adjust such amounts in accordance with such section if the amounts are not inherently reasonable.

(2) ITEMS DESCRIBED.—The items referred to in paragraph (1) are decubitus care equipment, transcutaneous electrical nerve stimulators, and any other items considered appropriate by the Secretary.

SEC. 8425. MISCELLANEOUS AND TECHNICAL CORRECTIONS.

(a) UPDATES TO PAYMENT AMOUNTS.—(1) Subparagraph (A) of section 1834(a)(14) (42 U.S.C. 1395m(a)(14)) is amended to read as follows:

"(A) for 1991 and 1992, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year reduced by 1 percentage point; and".

(2) The amendment made by paragraph (1) shall be effective on the date of the enactment of this Act.

(b) ADVANCE DETERMINATIONS OF COVERAGE.—(1) Effective on the expiration of the 60-day period that begins on the date of the enactment of this Act, section 1834(a)(15) (42 U.S.C. 1395m(a)(15)) is amended to read as follows:

"(15) ADVANCE DETERMINATIONS OF COVERAGE FOR CERTAIN ITEMS.—

"(A) DEVELOPMENT OF LISTS OF ITEMS BY SECRETARY.—The Secretary may develop and periodically update a list of items for which payment may be made under this subsection that the Secretary determines, on the basis of prior payment experience, are frequently subject to unnecessary utilization throughout a carrier's entire service area or a portion of such area.

"(B) DEVELOPMENT OF LISTS OF SUPPLIERS BY SECRETARY.—The Secretary may develop and periodically update a list of suppliers of items for which payment may be made under this subsection with respect to whom—

"(i) the Secretary has found that a substantial number of claims for payment under this part for items furnished by the supplier have been denied on the basis of the application of section 1862(a)(1); or

"(ii) the Secretary has identified a pattern of overutilization resulting from the business practice of the supplier.

"(C) DETERMINATIONS OF COVERAGE IN ADVANCE.—A carrier shall determine in advance of delivery of an item whether payment for the item may not be made because the item is not covered or because of the application of section 1862(a)(1) if—

"(i) the item is included on the list developed by the Secretary under subparagraph (A);

"(ii) the item is furnished by a supplier included on the list developed by the Secretary under subparagraph (B); or

"(iii) the item is a customized item (other than inexpensive items specified by the Secretary) and the patient to whom the item is to be furnished or the supplier requests that such advance determination be made."

(2) Effective for standards applied for contract years beginning after the date of the enactment of this Act, section 1842(c) (42 U.S.C. 1395u(c)), as amended by section 8415(a), is amended by adding at the end the following new paragraph:

"(5) Each contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B), shall require the carrier to meet criteria developed by the Secretary to measure the timeliness of carrier responses to requests for payment of items described in section 1834(a)(15)(C)."

(3) Effective on the date of the enactment of this Act, section 1834(h)(3) (42 U.S.C. 1395m(h)(3)), as amended by section 8423(b), is amended by striking "(12) and (17)" and inserting "(12), (15), and (17)".

(c) STUDY OF VARIATIONS IN DURABLE MEDICAL EQUIPMENT SUPPLIER COSTS.—

(1) COLLECTION AND ANALYSIS OF SUPPLIER COST DATA.—The Administrator of the Health Care Financing Administration shall, in consultation with appropriate organizations, collect data on supplier costs of durable medical equipment for which payment may be made under part B of the medicare program, and shall analyze such data to determine the proportions of such costs attributable to the service and product components of furnishing such equipment and the extent to which such proportions vary by type of equipment and by the geographic region in which the supplier is located.

(2) DEVELOPMENT OF GEOGRAPHIC ADJUSTMENT INDEX; REPORTS.—Not later than 6 months after collecting and analyzing the data described in paragraph (1)—

(A) the Administrator shall submit a report to the Committees on Energy and Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate on the data collected and the analysis conducted under paragraph (1), and shall include in such report the Administrator's recommendations for a geographic cost adjustment index for suppliers of durable medical equipment under the medicare program and an analysis of the impact of such proposed index on payments under the medicare program; and

(B) the Comptroller General shall submit a report to the Committees on Energy and Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate analyzing on a geo-

graphic basis the supplier costs of durable medical equipment under the medicare program.

(d) OXYGEN RETESTING.—(1) Section 1834(a)(5)(E) (42 U.S.C. 1395m(a)(5)(E)) is amended by striking “55” and inserting “56”.

(2) The amendment made by paragraph (1) shall be effective on the date of the enactment of this Act.

(e) OTHER MISCELLANEOUS AND TECHNICAL AMENDMENTS.—(1) Section 4152(a)(3) of OBRA-1990 is amended by striking “amendment made by subsection (a)” and inserting “amendments made by this subsection”.

(2) Section 4152(c)(2) of OBRA-1990 is amended by striking “1395m(a)(7)(A)” and inserting “1395m(a)(7)”.

(3) Section 1834(a)(7)(A)(iii)(II) (42 U.S.C. 1395m(a)(7)(A)(iii)(II)) is amended by striking “clause (v)” and inserting “clause (vi)”.

(4) Section 1834(a)(7)(C)(i) (42 U.S.C. 1395m(a)(7)(C)(i)) is amended by striking “or paragraph (3)”.

(5) Section 1834(a)(3) (42 U.S.C. 1395m(a)(3)) is amended by striking subparagraph (D).

(6) Section 4153(c)(1) of OBRA-1990 is amended by striking “1834(a)” and inserting “1834(h)”.

(7) Section 4153(d)(2) of OBRA-1990 is amended by striking “Reconciliation” and inserting “Reconciliation”.

(8) The amendments made by this subsection shall take effect as if included in the enactment of OBRA-1990.

Subpart C—Other Items and Services

SEC. 8431. AMBULATORY SURGICAL CENTER SERVICES.

(a) PAYMENT AMOUNTS FOR SERVICES FURNISHED IN AMBULATORY SURGICAL CENTERS.—

(1) USE OF SURVEY TO DETERMINE INCURRED COSTS.—Section 1833(i)(2)(A)(i) (42 U.S.C. 1395l(i)(2)(A)(i)) is amended by striking the comma at the end and inserting the following: “, as determined in accordance with a survey (based upon a representative sample of procedures and facilities) taken not later than January 1, 1995, and every 5 years thereafter, of the actual audited costs incurred by such centers in providing such services.”.

(2) AUTOMATIC APPLICATION OF INFLATION ADJUSTMENT.—Section 1833(i)(2) (42 U.S.C. 1395l(i)(2)) is amended—

(A) in the second sentence of subparagraph (A) and the second sentence of subparagraph (B), by striking “and may be adjusted by the Secretary, when appropriate,”; and

(B) by adding at the end the following new subparagraph:

“(C) Notwithstanding the second sentence of subparagraph (A) or the second sentence of subparagraph (B), if the Secretary has not updated amounts established under such subparagraphs with respect to facility services furnished during a fiscal year (beginning with fiscal year 1996), such amounts shall be increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved.”.

(3) CONSULTATION REQUIREMENT.—The second sentence of section 1833(i)(1) (42 U.S.C. 1395l(i)(1)) is amended by striking the period and inserting the following: “, in consultation with appropriate trade and professional organizations.”.

(b) ADJUSTMENTS TO PAYMENT AMOUNTS FOR NEW TECHNOLOGY INTRAOCULAR LENSES.—

(1) ESTABLISHMENT OF PROCESS FOR REVIEW OF AMOUNTS.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services (in this subsection referred to as the “Secretary”) shall develop and implement a process under which interested parties may request review by the Secretary of the appropriateness of the reimbursement amount provided under section 1833(i)(2)(A)(iii) of the Social Security Act with respect to a class of new technology intraocular lenses. For purposes of the preceding sentence, an intraocular lens may not be treated as a new technology lens unless it has been approved by the Food and Drug Administration.

(2) FACTORS CONSIDERED.—In determining whether to provide an adjustment of payment with respect to a particular lens under paragraph (1), the Secretary shall take into account whether use of the lens is likely to result in reduced risk of intraoperative or postoperative complication or trauma, accelerated post-

operative recovery, reduced induced astigmatism, improved postoperative visual acuity, more stable postoperative vision, or other comparable clinical advantages.

(3) NOTICE AND COMMENT.—The Secretary shall publish notice in the Federal Register from time to time (but no less often than once each year) of a list of the requests that the Secretary has received for review under this subsection, and shall provide for a 30-day comment period on the lenses that are the subjects of the requests contained in such notice. The Secretary shall publish a notice of the Secretary's determinations with respect to intraocular lenses listed in the notice within 90 days after the close of the comment period.

(4) EFFECTIVE DATE OF ADJUSTMENT.—Any adjustment of a payment amount (or payment limit) made under this subsection shall become effective not later than 30 days after the date on which the notice with respect to the adjustment is published under paragraph (3).

(c) TECHNICAL CORRECTION RELATING TO BLEND AMOUNTS FOR AMBULATORY SURGICAL CENTER PAYMENTS.—

(1) IN GENERAL.—Subclauses (I) and (II) of section 1833(i)(3)(B)(ii) (42 U.S.C. 1395l(i)(3)(B)(ii)) are each amended—

(A) by striking “for reporting” and inserting “for portions of cost reporting”; and

(B) by striking “and on or before” and inserting “and ending on or before”.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect as if included in the enactment of OBRA-1990.

(d) TECHNICAL CORRECTION RELATED TO CATARACT SURGERY.—Effective as if included in the enactment of OBRA-1990, section 4151(c)(3) of such Act is amended by striking “for the insertion of an intraocular lens” and inserting “for an intraocular lens inserted”.

SEC. 8432. STUDY OF MEDICARE COVERAGE OF PATIENT CARE COSTS ASSOCIATED WITH CLINICAL TRIALS OF NEW CANCER THERAPIES.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study of the effects of expressly covering under the medicare program the patient care costs for beneficiaries enrolled in clinical trials of new cancer therapies, where the protocol for the trial has been approved by the National Cancer Institute or meets similar scientific and ethical standards, including approval by an institutional review board. The study shall include—

(1) an estimate of the cost of such coverage, taking into account the extent to which medicare currently pays for such patient care costs in practice;

(2) an assessment of the extent to which such clinical trials represent the best available treatment for the patients involved and of the effects of participation in the trials on the health of such patients;

(3) an assessment of whether progress in developing new anticancer therapies would be assisted by medicare coverage of such patient care costs; and

(4) an evaluation of whether there should be special criteria for the admission of medicare beneficiaries (on account of their age or physical condition) to clinical trials for which medicare would pay the patient care costs.

(b) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit a report on the study conducted under subsection (a) to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate. Such report shall include recommendations as to the coverage under the medicare program of patient care costs of beneficiaries enrolled in clinical trials of new cancer therapies.

SEC. 8433. STUDY OF ANNUAL CAP ON AMOUNT OF MEDICARE PAYMENT FOR OUTPATIENT PHYSICAL THERAPY AND OCCUPATIONAL THERAPY SERVICES.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study of the appropriateness of continuing an annual limitation on the amount of payment for outpatient services of independently practicing physical and occupational therapists under the medicare program.

(b) REPORT.—By not later than January 1, 1996, the Secretary shall submit to the Committees on Energy and Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report on the study conducted under subsection (a). Such report shall include such recommendations for changes in such annual limitation as the Secretary finds appropriate.

SEC. 8434. PAYMENT OF PART B PREMIUM LATE ENROLLMENT PENALTIES BY STATES.

Section 1839 (42 U.S.C. 1395r) is amended by adding at the end the following new subsection:

“(g)(1) Upon the request of a State, the Secretary may enter into an agreement with the State under which the State agrees to pay on a quarterly or other periodic basis to the Secretary (to be deposited in the Treasury to the credit of the Federal Supplementary Medical Insurance Trust Fund) an amount equal to the amount of the part B late enrollment premium increases with respect to the premiums for eligible individuals (as defined in paragraph (3)(A)).

“(2) No part B late enrollment premium increase shall apply to an eligible individual for premiums for months for which the amount of such an increase is payable under an agreement under paragraph (1).

“(3) In this subsection:

“(A) The term ‘eligible individual’ means an individual who is enrolled under this part B and who is within a class of individuals specified in the agreement under paragraph (1).

“(B) The term ‘part B late enrollment premium increase’ means any increase in a premium as a result of the application of subsection (b).”.

SEC. 8435. TREATMENT OF INPATIENTS AND PROVISION OF DIAGNOSTIC X-RAY SERVICES BY RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS.

(a) TREATMENT OF INPATIENTS.—Section 1861(aa) (42 U.S.C. 1395x(aa)) is amended—

(1) in paragraph (1), in the matter following subparagraph (C), by striking “as an outpatient” and inserting “as a patient”;

(2) in paragraph (2)(A), by striking “furnishing to outpatients” and inserting “furnishing to patients”; and

(3) in paragraph (3), in the matter following subparagraph (B), by striking “as an outpatient” and inserting “as a patient”.

(b) TREATMENT OF DIAGNOSTIC X-RAY SERVICES.—Section 1861(aa) (42 U.S.C. 1395x(aa)) is further amended—

(1) in paragraph (1)(A), by inserting “(i)” after “(A)” and by adding at the end the following: “and (ii) diagnostic x-ray services,” and

(2) in paragraph (2)(A), by striking “(A)” and inserting “(A)(i)”.

(c) CONFORMING AMENDMENT.—Section 1862(a)(14) (42 U.S.C. 1395y(a)(14)) is amended by striking “and services of a certified registered nurse anesthetist” and inserting “services of a certified registered nurse anesthetist, rural health clinic services, and Federally-qualified health center services”.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1995, and shall apply to services furnished on or after such date.

SEC. 8436. APPLICATION OF MAMMOGRAPHY CERTIFICATION REQUIREMENTS.

(a) SCREENING MAMMOGRAPHY.—Section 1834(c) (42 U.S.C. 1395m(c)) is amended—

(1) in paragraph (1)(B), by striking “meets the quality standards established under paragraph (3)” and inserting “is conducted by a facility that has a certificate (or provisional certificate) issued under section 354 of the Public Health Service Act”;

(2) in paragraph (1)(C)(iii), by striking “paragraph (4)” and inserting “paragraph (3)”;

(3) by striking paragraph (3); and

(4) by redesignating paragraphs (4) and (5) as paragraphs (3) and (4).

(b) DIAGNOSTIC MAMMOGRAPHY.—Section 1861(s)(3) (42 U.S.C. 1395x(s)(3)) is amended by inserting “and including diagnostic mammography if conducted by a facility that has a certificate (or provisional certificate) issued under section 354 of the Public Health Service Act” after “necessary”.

(c) CONFORMING AMENDMENTS.—(1) Section 1862(a)(1)(F) (42 U.S.C. 1395y(a)(1)(F)) is amended by striking “or which does not meet the standards established under section 1834(c)(3)” and inserting “or which is not conducted by a facility described in section 1834(c)(1)(B)”.

(2) Section 1863 (42 U.S.C. 1395z) is amended by striking “or whether screening mammography meets the standards established under section 1834(c)(3).”.

(3) The first sentence of section 1864(a) (42 U.S.C. 1395aa(a)) is amended by striking “, or whether screening mammography meets the standards established under section 1834(c)(3).”.

(4) The third sentence of section 1865(a) (42 U.S.C. 1395bb(a)) is amended by striking “1834(c)(3).”.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to mammography furnished by a facility on and after the first date that the certificate requirements of section 354(b) of the Public Health Service Act apply to such mammography conducted by such facility.

SEC. 8437. COVERAGE OF SERVICES OF SPEECH-LANGUAGE PATHOLOGISTS AND AUDIOLOGISTS.

(a) **SERVICES DEFINED.**—Section 1861 (42 U.S.C. 1395x), as amended by section 8438(f)(6)(E), is amended by inserting after subsection (kk) the following new subsection:

“Speech-Language Pathology Services; Audiology Services

“(1)(1) The term ‘speech-language pathology services’ means such speech, language, and related function assessment and rehabilitation services furnished by a qualified speech-language pathologist as the speech-language pathologist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) as would otherwise be covered if furnished by a physician.

“(2) The term ‘audiology services’ means such hearing and balance assessment services furnished by a qualified audiologist as the audiologist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), as would otherwise be covered if furnished by a physician.

“(3) In this subsection:

“(A) The term ‘qualified speech-language pathologist’ means an individual with a master’s or doctoral degree in speech-language pathology who—

“(i) is licensed as a speech-language pathologist by the State in which the individual furnishes such services, or

“(ii) in the case of an individual who furnishes services in a State which does not license speech-language pathologists, has successfully completed 350 clock hours of supervised clinical practicum (or is in the process of accumulating such supervised clinical experience), performed not less than 1 month of supervised full-time speech-language pathology services after obtaining a master’s or doctoral degree in speech-language pathology or a related field, and successfully completed a national examination in speech-language pathology approved by the Secretary.

“(B) The term ‘qualified audiologist’ means an individual with a master’s or doctoral degree in audiology who—

“(i) is licensed as a speech-language pathologist by the State in which the individual furnishes such services, or

“(ii) in the case of an individual who furnishes services in a State which does not license speech-language pathologists, has successfully completed 350 clock hours of supervised clinical practicum (or is in the process of accumulating such supervised clinical experience), performed not less than 1 month of supervised full-time speech-language pathology services after obtaining a master’s or doctoral degree in speech-language pathology or a related field, and successfully completed a national examination in speech-language pathology approved by the Secretary.”.

(b) **CONFORMING AMENDMENTS RELATING TO MEDICARE TREATMENT OF SPEECH AND LANGUAGE SERVICES.**—

(1) **EXTENDED CARE SERVICES.**—Section 1861(h)(3) (42 U.S.C. 1395x(h)(3)) is amended by striking “, occupational, or speech therapy” and inserting “or occupational therapy or speech-language pathology services”.

(2) **HOME HEALTH SERVICES.**—Section 1861(m)(2) (42 U.S.C. 1395x(m)(2)) is amended by striking “, occupational, or speech therapy” and inserting “or occupational therapy or speech-language pathology services”.

(3) **OUTPATIENT PHYSICAL THERAPY SERVICES.**—The fourth sentence of section 1861(p) (42 U.S.C. 1395x(p)) is amended by striking “speech pathology services” and inserting “speech-language pathology services”.

(4) **COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY SERVICES.**—Section 1861(cc)(1)(B) (42 U.S.C. 1395x(cc)(1)(B)) is amended by striking “speech pathology services” and inserting “speech-language pathology services”.

(5) **HOSPICE CARE.**—Section 1861(dd)(1)(B) (42 U.S.C. 1395x(dd)(1)(B)) is amended by striking “therapy or speech-language pathology” and inserting “therapy, or speech-language pathology services”.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall take effect on the date of the enactment of this Act.

SEC. 8438. MISCELLANEOUS AND TECHNICAL CORRECTIONS.

(a) **REVISION OF INFORMATION ON PART B CLAIMS FORMS.**—Section 1833(q)(1) (42 U.S.C. 1395l(q)(1)) is amended—

(1) by striking “provider number” and inserting “unique physician identification number”; and

(2) by striking “and indicate whether or not the referring physician is an interested investor (within the meaning of section 1877(h)(5))”.

(b) CONSULTATION FOR SOCIAL WORKERS.—Effective with respect to services furnished on or after January 1, 1991, section 6113(c) of OBRA-1989 is amended—

(1) by inserting “and clinical social worker services” after “psychologist services”; and

(2) by striking “psychologist” the second and third place it appears and inserting “psychologist or clinical social worker”.

(c) REPORTS ON HOSPITAL OUTPATIENT PAYMENT.—(1) OBRA-1989 is amended by striking section 6137.

(2) Section 1135(d) (42 U.S.C. 1320b-5(d)) is amended—

(A) by striking paragraph (6); and

(B) in paragraph (7)—

(i) by striking “systems” each place it appears and inserting “system”; and

(ii) by striking “paragraphs (1) and (6)” and inserting “paragraph (1)”.

(d) RADIOLOGY AND DIAGNOSTIC SERVICES PROVIDED IN HOSPITAL OUTPATIENT DEPARTMENTS.—(1) Effective as if included in the enactment of OBRA-1989, section 1833(n)(1)(B)(i)(II) (42 U.S.C. 1395l(n)(1)(B)(i)(II)) is amended—

(A) by inserting “and for services described in subsection (a)(2)(E)(ii) furnished on or after January 1, 1992” after “1989”; and

(B) by striking “1842(b)” and inserting “1842(b) (or, in the case of services furnished on or after January 1, 1992, under section 1848)”.

(2) Effective as if included in the enactment of OBRA-1989, section 1833(n)(1)(B)(i)(II) (42 U.S.C. 1395l(n)(1)(B)(i)(II)) is amended by striking “January 1, 1989” and inserting “April 1, 1989”.

(e) PAYMENTS TO NURSE PRACTITIONERS IN RURAL AREAS (SECTION 4155 OF OBRA-1990).—(1) Section 1861(s)(2)(K)(iii) (42 U.S.C. 1395x(s)(2)(K)(iii)) is amended—

(A) by striking “subsection (aa)(3)” and inserting “subsection (aa)(5)”; and

(B) by striking “subsection (aa)(4)” and inserting “subsection (aa)(6)”.

(2) Section 1833(r)(1) (42 U.S.C. 1395l(r)(1)) is amended—

(A) by striking “ambulatory” each place it appears and inserting “or ambulatory”; and

(B) by striking “center,” and inserting “center”.

(3) Section 1833(r)(2)(A) (42 U.S.C. 1395l(r)(2)(A)) is amended by striking “subsection (a)(1)(M)” and inserting “subsection (a)(1)(O)”.

(4) Section 1861(b)(4) (42 U.S.C. 1395x(b)(4)) is amended by striking “subsection (s)(2)(K)(i)” and inserting “clauses (i) or (iii) of subsection (s)(2)(K)”.

(5) Section 1861(aa)(5) (42 U.S.C. 1395x(aa)(5)) is amended by striking “this Act” and inserting “this title”.

(6) Section 1862(a)(14) (42 U.S.C. 1395y(a)(14)) is amended by striking “1861(s)(2)(K)(i)” and inserting “1861(s)(2)(K)(i) or 1861(s)(2)(K)(iii)”.

(7) Section 1866(a)(1)(H) (42 U.S.C. 1395cc(a)(1)(H)) is amended by striking “1861(s)(2)(K)(i)” and inserting “1861(s)(2)(K)(i) or 1861(s)(2)(K)(iii)”.

(f) OTHER MISCELLANEOUS AND TECHNICAL AMENDMENTS.—

(1) IMMEDIATE ENROLLMENT IN PART B BY INDIVIDUALS COVERED BY AN EMPLOYMENT-BASED PLAN.—(A) Subparagraphs (A) and (B) of section 1837(i)(3) (42 U.S.C. 1395p(i)(3)) are each amended—

(i) by striking “beginning with the first day of the first month in which the individual is no longer enrolled” and inserting “including each month during any part of which the individual is enrolled”; and

(ii) by striking “and ending seven months later” and inserting “ending with the last day of the eighth consecutive month in which the individual is at no time so enrolled”.

(B) Paragraphs (1) and (2) of section 1838(e) (42 U.S.C. 1395q(e)) are amended to read as follows:

“(1) in any month of the special enrollment period in which the individual is at any time enrolled in a plan (specified in subparagraph (A) or (B), as applicable, of section 1837(i)(3)) or in the first month following such a month, the coverage period shall begin on the first day of the month in which the individual so enrolls (or, at the option of the individual, on the first day of any of the following three months), or

“(2) in any other month of the special enrollment period, the coverage period shall begin on the first day of the month following the month in which the individual so enrolls.”

(C) The amendments made by subparagraphs (A) and (B) shall take effect on the first day of the first month that begins after the expiration of the 120-day period that begins on the date of the enactment of this Act.

(2) CLINICAL DIAGNOSTIC LABORATORY TESTS.—Section 4154(e)(5) of OBRA-1990 is amended by striking “(1)(A)” and inserting “(1)(A),”.

(3) SEPARATE PAYMENT UNDER PART B FOR CERTAIN SERVICES.—Section 4157(a) of OBRA-1990 is amended by striking “(a) SERVICES OF” and all that follows through “Section” and inserting “(a) TREATMENT OF SERVICES OF CERTAIN HEALTH PRACTITIONERS.—Section”.

(4) COMMUNITY HEALTH CENTERS AND RURAL HEALTH CLINICS.—(A) The fourth sentence of section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)) is amended—

(i) by striking “certification” the first place it appears and inserting “approval”; and

(ii) by striking “the Secretary’s approval or disapproval of the certification” and inserting “Secretary’s approval or disapproval”.

(B) Section 4161(a)(7)(B) of OBRA-1990 is amended by inserting “and to the Committee on Finance of the Senate” after “Representatives”.

(5) SCREENING MAMMOGRAPHY.—Section 4163 of OBRA-1990 is amended—

(A) by adding at the end of subsection (d) the following new paragraph: “(3) The amendment made by paragraph (2)(A)(iv) shall apply to screening pap smears performed on or after July 1, 1990.”; and

(B) in subsection (e), by striking “The amendments” and inserting “Except as provided in subsection (d)(3), the amendments”.

(6) INJECTABLE DRUGS FOR TREATMENT OF OSTEOPOROSIS.—

(A) CLARIFICATION OF DRUGS COVERED.—The section 1861(jj) (42 U.S.C. 1395x(jj)) inserted by section 4156(a)(2) of OBRA-1990 is amended—

(i) in the matter preceding paragraph (1), by striking “a bone fracture related to”; and

(ii) in paragraph (1), by striking “patient” and inserting “individual has suffered a bone fracture related to post-menopausal osteoporosis and that the individual”.

(B) LIMITING COVERAGE TO DRUGS PROVIDED BY HOME HEALTH AGENCIES.—(i) The section 1861(jj) (42 U.S.C. 1395x(jj)) inserted by section 4156(a)(2) of OBRA-1990 is amended by striking “if” and inserting “by a home health agency if”.

(ii) Section 1861(m)(5) (42 U.S.C. 1395x(m)(5)) is amended by striking “but excluding” and inserting “and a covered osteoporosis drug (as defined in subsection (kk), but excluding other”.

(iii) Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

(I) by adding “and” at the end of subparagraph (N), and

(II) by striking subparagraph (O) and redesignating subparagraph (P) as subparagraph (O).

(C) PAYMENT BASED ON REASONABLE COST.—Section 1833(a)(2) (42 U.S.C. 1395l(a)(2)) is amended—

(i) in subparagraph (A), by striking “health services” and inserting “health services (other than a covered osteoporosis drug (as defined in section 1861(kk)))”;

(ii) by striking “and” at the end of subparagraph (D);

(iii) by striking the semicolon at the end of subparagraph (E) and inserting “, and”; and

(iv) by adding at the end the following new subparagraph:

“(F) with respect to a covered osteoporosis drug (as defined in section 1861(kk)) furnished by a home health agency, 80 percent of the reasonable cost of such service, as determined under section 1861(v);”.

(D) APPLICATION OF PART B DEDUCTIBLE.—Section 1833(b)(2) (42 U.S.C. 1395l(b)(2)) is amended by striking “services” and inserting “services (other than a covered osteoporosis drug (as defined in section 1861(kk)))”.

(E) COVERED OSTEOPOROSIS DRUG (SECTION 4156 OF OBRA-1990).—Section 1861 (42 U.S.C. 1395x) is amended, in the subsection (jj) inserted by section 4156(a)(2) of OBRA-1990, by striking “(jj) The term” and inserting “(kk) The term”.

(7) OTHER MISCELLANEOUS AND TECHNICAL CORRECTIONS.—

(A) OWNERSHIP DISCLOSURE REQUIREMENTS.—(i) Section 1124A(a)(2)(A) (42 U.S.C. 1320a-3a(a)(2)(A)) is amended by striking “of the Social Security Act”.

(ii) Section 4164(b)(4) of OBRA-1990 is amended by striking “paragraph” and inserting “paragraphs”.

(B) DIRECTORY OF UNIQUE PHYSICIAN IDENTIFIER NUMBERS.—Section 4164(c) of OBRA-1990 is amended by striking “publish” and inserting “publish, and shall periodically update,”.

(g) **EFFECTIVE DATE.**—Except as otherwise provided in this section, the amendments made by this section shall take effect as if included in the enactment of OBRA-1990.

PART 3—PROVISIONS RELATING TO PARTS A AND B

Subpart A—Medicare Secondary Payer

SEC. 8441. MEDICARE SECONDARY PAYER REFORMS.

(a) IMPROVING IDENTIFICATION OF MEDICARE SECONDARY PAYER SITUATIONS.—

(1) SURVEY OF BENEFICIARIES.—

(A) **IN GENERAL.**—Section 1862(b)(5) (42 U.S.C. 1395y(b)(5)) is amended by adding at the end the following new subparagraph:

“(D) **OBTAINING INFORMATION FROM BENEFICIARIES.**—Before an individual applies for benefits under part A or enrolls under part B, the Administrator shall mail the individual a questionnaire to obtain information on whether the individual is covered under a primary plan and the nature of the coverage provided under the plan, including the name, address, and identifying number of the plan.”

(B) **DISTRIBUTION OF QUESTIONNAIRE BY CONTRACTOR.**—The Secretary of Health and Human Services shall enter into an agreement with an entity not later than the expiration of the 60-day period that begins on the date of the enactment of this Act, to distribute the questionnaire described in section 1862(b)(5)(D) of the Social Security Act (as added by subparagraph (A)).

(C) **NO MEDICARE SECONDARY PAYER DENIAL BASED ON FAILURE TO COMPLETE QUESTIONNAIRE.**—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended by adding at the end the following new subparagraph:

“(C) **TREATMENT OF QUESTIONNAIRES.**—The Secretary may not fail to make payment under subparagraph (A) solely on the ground that an individual failed to complete a questionnaire concerning the existence of a primary plan.”

(2) MANDATORY SCREENING BY PROVIDERS AND SUPPLIERS UNDER PART B.—

(A) **IN GENERAL.**—Section 1862(b) (42 U.S.C. 1395y(b)) is amended by adding at the end the following new paragraph:

“(6) **SCREENING REQUIREMENTS FOR PROVIDERS AND SUPPLIERS.**—

“(A) **IN GENERAL.**—Notwithstanding any other provision of this title, no payment may be made for any item or service furnished under part B unless the entity furnishing such item or service completes (to the best of its knowledge and on the basis of information obtained from the individual to whom the item or service is furnished) the portion of the claim form relating to the availability of other health benefit plans.

“(B) **PENALTIES.**—An entity that knowingly, willfully, and repeatedly fails to complete a claim form in accordance with subparagraph (A) or provides inaccurate information relating to the availability of other health benefit plans on a claim form under such subparagraph shall be subject to a civil money penalty of not to exceed \$2,000 for each such incident. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).”

(B) **EFFECTIVE DATE.**—The amendment made by subparagraph (A) shall apply with respect to items and services furnished on or after the expiration of the 120-day period that begins on the date of the enactment of this Act.

(b) IMPROVEMENTS IN RECOVERY OF PAYMENTS FROM PRIMARY PAYERS.—

(1) **SUBMISSION OF REPORTS ON EFFORTS TO RECOVER ERRONEOUS PAYMENTS.**—

(A) **FISCAL INTERMEDIARIES UNDER PART A.**—Section 1816 (42 U.S.C. 1396h) is amended by adding at the end the following new subsection:

“(k) An agreement with an agency or organization under this section shall require that such agency or organization submit an annual report to the Secretary describing the steps taken to recover payments made for items or services for which payment has been or could be made under a primary plan (as defined in section 1862(b)(2)(A)).”

(B) **CARRIERS UNDER PART B.**—Section 1842(b)(3) (42 U.S.C. 1395u(b)(3)) is amended—

- (i) by striking “and” at the end of subparagraph (G);
- (ii) by striking “and” at the end of subparagraph (H); and

(iii) by inserting after subparagraph (H) the following new subparagraph:

“(I) will submit annual reports to the Secretary describing the steps taken to recover payments made under this part for items or services for which payment has been or could be made under a primary plan (as defined in section 1862(b)(2)(A)); and”.

(2) REQUIREMENTS UNDER CARRIER PERFORMANCE EVALUATION PROGRAM.—

(A) FISCAL INTERMEDIARIES UNDER PART A.—Section 1816(f)(1)(A) (42 U.S.C. 1396h(f)(1)(A)) is amended by striking “processing” and inserting “processing (including the agency’s or organization’s success in recovering payments made under this title for services for which payment has been or could be made under a primary plan (as defined in section 1862(b)(2)(A)))”.

(B) CARRIERS UNDER PART B.—Section 1842(b)(2) (42 U.S.C. 1395u(b)(2)) is amended by adding at the end the following new subparagraph:

“(D) In addition to any other standards and criteria established by the Secretary for evaluating carrier performance under this paragraph relating to avoiding erroneous payments, the carrier shall be subject to standards and criteria relating to the carrier’s success in recovering payments made under this part for items or services for which payment has been or could be made under a primary plan (as defined in section 1862(b)(2)(A)).”.

(3) DEADLINE FOR REIMBURSEMENT BY PRIMARY PLANS.—

(A) IN GENERAL.—Section 1862(b)(2)(B)(i) (42 U.S.C. 1395y(b)(2)(B)(i)) is amended by adding at the end the following sentence: “If reimbursement is not made to the appropriate Trust Fund before the expiration of the 60-day period that begins on the date such notice or other information is received, the Secretary may charge interest (beginning with the date on which the notice or other information is received) on the amount of the reimbursement until reimbursement is made (at a rate determined by the Secretary in accordance with regulations of the Secretary of the Treasury applicable to charges for late payments).”.

(B) CONFORMING AMENDMENT.—The heading of clause (i) of section 1862(b)(2)(B) is amended to read as follows: “REPAYMENT REQUIRED.—”.

(C) EFFECTIVE DATE.—The amendments made by this paragraph shall apply to payments for items and services furnished on or after the date of the enactment of this Act.

(4) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (2) shall apply to contracts with fiscal intermediaries and carriers under title XVIII of the Social Security Act for contract years beginning on or after the date of the enactment of this Act.

(c) MISCELLANEOUS AND TECHNICAL CORRECTIONS.—

(1) Effective as if included in the enactment of OBRA–1993, section 1862(b)(1)(A) (42 U.S.C. 1395y(b)(1)(A)), as amended by section 13561(e)(1) of OBRA–1993, is amended—

(A) in clause (i)(II), by striking “over (and the individual’s spouse age 65 or older) who is covered under the plan by virtue of the individual’s current employment status with an employer” and inserting “older (and the spouse age 65 or older of any individual) who has current employment status with an employer”; and

(B) in clause (ii), by striking “or employee organization that has 20 or more individuals in current employment status” and inserting “that has 20 or more employees”.

(2) Effective as if included in the enactment of OBRA–1993, section 1837(i) (42 U.S.C. 1395p(i)) is amended—

(A) by striking “as an active individual (as those terms are defined in section 1862(b)(1)(B)(iv))” each place it appears in the second sentence of paragraph (1), and the second sentence of paragraph (2) and inserting “(as that term is defined in section 1862(b)(1)(B)(iv)) by reason of the individual’s current employment status (or the current employment status of a family member of the individual)”;

(B) in paragraph (3)(B), by striking “as an active individual in a large group health plan (as such terms are defined in section 1862(b)(1)(B)(iv))” and inserting “in a large group health plan (as that term is defined in section 1862(b)(1)(B)(iv)) by reason of the individual’s current employment status (or the current employment status of a family member of the individual)”;

(C) in the second sentence of paragraph (2) (as amended by subparagraph (A)), by striking “as an active individual” and inserting “by reason of the

individual's current employment status (or the current employment status of a family member of the individual)"; and

(D) by inserting "status" after "current employment" each place it appears in paragraphs (1)(A), (2)(B), (2)(C), and (3)(A).

(3) Effective as if included in the enactment of OBRA-1993, the second sentence of section 1839(b) (42 U.S.C. 1395r(b)) is amended—

(A) by inserting "status" after "current employment", and

(B) by striking "as an active individual (as those terms are defined in section 1862(b)(1)(B)(iv))" and inserting "(as that term is defined in section 1862(b)(1)(B)(iv)) by reason of the individual's current employment status (or the current employment status of a family member of the individual)".

(4) Effective as if included in the enactment of OBRA-1990, the sentence in section 1862(b)(1)(C) added by section 4203(c)(1)(B) of OBRA-1990 is amended by striking "clauses (i) and (ii)" and inserting "this subparagraph".

(5) Effective as if included in the enactment of OBRA-1989, section 1862(b)(1)(C) is amended in the matter after clause (ii), by striking "taking into account that" and inserting "paying benefits secondary to this title when".

(6) Effective as if included in the enactment of OBRA-1989, section 1862(b)(5)(C)(i) (42 U.S.C. 1395y(b)(5)(C)(i)) is amended by striking "6103(l)(12)(D)(iii)" and inserting "6103(l)(12)(E)(iii)".

(7) Effective as if included in the enactment of OBRA-1990, section 4203(c)(2) of such Act is amended—

(A) by striking "the application of clause (iii)" and inserting "the second sentence";

(B) by striking "on individuals" and all that follows through "section 226A of such Act";

(C) in clause (ii), by striking "clause" and inserting "sentence";

(D) in clause (v), by adding "and" at the end; and

(E) in clause (vi)—

(i) by inserting "of such Act" after "1862(b)(1)(C)", and

(ii) by striking the period at the end and inserting the following: ", without regard to the number of employees covered by such plans."

(8) Effective as if included in the enactment of OBRA-1990, section 4203(d) of OBRA-1990 is amended by striking "this subsection" and inserting "this section".

(9) Effective as if included in the enactment of OBRA-1993, section 13561(e)(1)(D) of OBRA-1993 is amended—

(A) by inserting "effective as if included in the enactment of OBRA-1989," after "(D)", and

(B) by striking "of each subparagraph".

(10) The amendment made by section 13561(e)(1)(G) of OBRA-1993, to the extent it relates to the definition of large group health plan, shall be effective as if included in the enactment of OBRA-1989.

Subpart B—Other Items and Services Relating to Parts A and B

SEC. 8451. DEFINITION OF FMGEMS EXAMINATION FOR PAYMENT OF DIRECT GRADUATE MEDICAL EDUCATION.

(a) IN GENERAL.—Section 1886(h)(5)(E) (42 U.S.C. 1395ww(h)(5)(E)) is amended by inserting "or any successor examination" after "Medical Sciences".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply as if included in the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272).

SEC. 8452. QUALIFIED MEDICARE BENEFICIARY OUTREACH.

Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall establish and implement a method for obtaining information from newly eligible medicare beneficiaries that may be used to determine whether such beneficiaries may be eligible for medical assistance for medicare cost-sharing under State medicaid plans as qualified medicare beneficiaries, and for transmitting such information to the State in which such a beneficiary resides.

SEC. 8453. HOSPITAL AGREEMENTS WITH ORGAN PROCUREMENT ORGANIZATIONS.

(a) HOSPITAL AGREEMENTS.—

(1) IN GENERAL.—

(A) IDENTIFICATION OF ORGAN DONORS.—Section 1138(a)(1)(A)(iii) (42 U.S.C. 1320b-8(a)(1)(A)(iii)) is amended to read as follows:

“(iii) require that such hospital’s designated organ procurement agency (as defined in paragraph (3)(B)) is notified of potential organ donors;”.

(B) AGREEMENTS WITH DESIGNATED ORGAN PROCUREMENT AGENCIES.—Section 1138(a)(1) (42 U.S.C. 1320b-8(a)(1)) is amended—

(i) by striking the period at the end of subparagraph (B) and inserting “; and”; and

(ii) by adding at the end the following new subparagraph:

“(C) the hospital or rural primary care hospital has an agreement (as defined in paragraph (3)(A)) only with such hospital’s designated organ procurement agency.”.

(C) WAIVER OF REQUIREMENTS RELATED TO AGREEMENTS.—Section 1138(a) (42 U.S.C. 1320b-8(a)) is amended—

(i) by redesignating paragraph (2) as paragraph (3); and

(ii) by inserting after paragraph (1) the following new paragraph:

“(2)(A) The Secretary shall grant a waiver of the requirements under subparagraphs (A)(iii) and (C) of paragraph (1) to a hospital or rural primary care hospital desiring to enter into an agreement with an organ procurement agency other than such hospital’s designated organ procurement agency if the Secretary determines that—

“(i) the waiver is expected to increase organ donation; and

“(ii) the waiver will assure equitable treatment of patients referred for transplants within the service area served by such hospital’s designated organ procurement agency and within the service area served by the organ procurement agency with which the hospital seeks to enter into an agreement under the waiver.

“(B) In making a determination under subparagraph (A), the Secretary may consider factors that would include, but not be limited to—

“(i) cost effectiveness;

“(ii) improvements in quality;

“(iii) whether there has been any change in a hospital’s designated organ procurement agency due to a change made on or after December 28, 1992, in the definitions for metropolitan statistical areas (as established by the Office of Management and Budget); and

“(iv) the length and continuity of a hospital’s relationship with an organ procurement agency other than the hospital’s designated organ procurement agency;

except that nothing in this subparagraph shall be construed to permit the Secretary to grant a waiver that does not meet the requirements of subparagraph (A).

“(C) Any hospital or rural primary care hospital seeking a waiver under subparagraph (A) shall submit an application to the Secretary containing such information as the Secretary determines appropriate.

“(D) The Secretary shall—

“(i) publish a public notice of any waiver application received from a hospital or rural primary care hospital under this paragraph within 30 days of receiving such application; and

“(ii) prior to making a final determination on such application under subparagraph (A), offer interested parties the opportunity to submit written comments to the Secretary during the 60-day period beginning on the date such notice is published.”.

(D) DEFINITIONS.—Section 1138(a)(3) (42 U.S.C. 1320b-8(a)(3)), as redesignated by subparagraph (C), is amended to read as follows:

“(3) For purposes of this subsection—

“(A) the term ‘agreement’ means an agreement described in section 371(b)(3)(A) of the Public Health Service Act;

“(B) the term ‘designated organ procurement agency’ means, with respect to a hospital or rural primary care hospital, the organ procurement agency designated pursuant to subsection (b) for the service area in which such hospital is located; and

“(C) the term ‘organ’ means a human kidney, liver, heart, lung, pancreas, and any other human organ or tissue specified by the Secretary for purposes of this subsection.”.

(2) EXISTING AGREEMENTS.—Any hospital or rural primary care hospital which has an agreement (as defined in section 1138(a)(3)(A) of the Social Security Act) with an organ procurement agency other than such hospital’s designated organ procurement agency (as defined in section 1138(a)(3)(B) of such Act) on the date of the enactment of this section shall, if such hospital desires

to continue such agreement on and after the effective date of the amendments made by paragraph (1), submit an application to the Secretary for a waiver under section 1138(a)(2) of such Act not later than January 1, 1995, and such agreement may continue in effect pending the Secretary's determination with respect to such application.

(3) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to hospitals and rural primary care hospitals participating in the programs under titles XVIII and XIX of the Social Security Act beginning January 1, 1995.

(b) STUDY ON HOSPITAL AGREEMENTS WITH ORGAN PROCUREMENT AGENCIES.—

(1) IN GENERAL.—The Office of Technology Assessment (referred to in this section as the “OTA”) shall, pursuant to the approval of the Technology Assessment Board of the OTA, conduct a study to determine the efficacy and fairness of requiring a hospital to enter into an agreement under section 371(b)(3)(A) of the Public Health Service Act with the organ procurement agency designated pursuant to section 1138(b) of the Social Security Act for the service area in which such hospital is located and the impact of such requirement on the efficacy and fairness of organ procurement and distribution.

(2) REPORT.—Not later than 2 years after the date of the enactment of this Act, the OTA shall complete the study required under paragraph (1) and prepare and submit to the Committee on Finance and the Committee on Labor and Human Resources of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report containing the findings of such study and the implications of such findings with respect to policies affecting organ procurement and distribution.

SEC. 8454. PEER REVIEW ORGANIZATIONS.

(a) REPEAL OF PRO PRECERTIFICATION REQUIREMENT FOR CERTAIN SURGICAL PROCEDURES.—

(1) IN GENERAL.—Section 1164 (42 U.S.C. 1320c–13) is repealed.

(2) CONFORMING AMENDMENTS.—

(A) Section 1154 (42 U.S.C. 1320c–3) is amended—

(i) in subsection (a), by striking paragraph (12), and

(ii) in subsection (d), by striking “(and except as provided in section 1164)”.

(B) Section 1833 (42 U.S.C. 1395l) is amended—

(i) in subsection (a)(1)(D)(i), by striking “, or for tests furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion)”;

(ii) in subsection (a)(1), by striking subparagraph (G);

(iii) in subsection (a)(2)(A), by striking “, to items and services (other than clinical diagnostic laboratory tests) furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion)”;

(iv) in subsection (a)(2)(D)(i)—

(I) by striking “basis,” and inserting “basis or”, and

(II) by striking “, or for tests furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion)”;

(v) in subsection (a)(3), by striking “and for items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2), or a third opinion, if the second opinion was in disagreement with the first opinion”; and

(vi) in the first sentence of subsection (b), by striking “(4)” and all that follows through “and (5)” and inserting “and (4)”.

(C) Section 1834(g)(1)(B) (42 U.S.C. 1395m(g)(1)(B)) is amended by striking “and for items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2), or a third opinion, if the second opinion was in disagreement with the first opinion”.

(D) Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(i) by adding “or” at the end of paragraph (14),

(ii) by striking “, or” at the end of paragraph (15) and inserting a period, and

(iii) by striking paragraph (16).

(E) The third sentence of section 1866(a)(2)(A) (42 U.S.C. 1395w(a)(2)(A)) is amended by striking “, with respect to items and services furnished in

connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion).”.

(3) **EFFECTIVE DATE.**—The amendments made by this subsection shall apply to services provided on or after the date of the enactment of this Act.

(b) **MISCELLANEOUS AND TECHNICAL CORRECTIONS.**—(1) The third sentence of section 1156(b)(1) (42 U.S.C. 1320c-5(b)(1)) is amended by striking “whehter” and inserting “whether”.

(2)(A) Section 1154(a)(9)(B) (42 U.S.C. 1320c-3(a)(9)(B)) is amended to read as follows:

“(B) If the organization finds, after reasonable notice to and opportunity for discussion with the physician or practitioner concerned, that the physician or practitioner has furnished services in violation of section 1156(a) and the organization determines that the physician or practitioner should enter into a corrective action plan under section 1156(b)(1), the organization shall notify the State board or boards responsible for the licensing or disciplining of the physician or practitioner of its finding and of any action taken as a result of the finding.”.

(B) Subparagraph (D) of section 1160(b)(1) (42 U.S.C. 1320c-9(b)(1)) is amended to read as follows:

“(D) to provide notice in accordance with section 1154(a)(9)(B);”.

(3) Section 4205(d)(2)(B) of OBRA-1990 is amended by striking “amendments” and inserting “amendment”.

(4) Section 1160(d) (42 U.S.C. 1320c-9(d)) is amended by striking “subpena” and inserting “subpoena”.

(5) Section 4205(e)(2) of OBRA-1990 is amended by striking “amendments” and inserting “amendment” and by striking “all”.

(6)(A) Except as provided in subparagraph (B), the amendments made by this subsection shall take effect as if included in the enactment of OBRA-1990.

(B) The amendments made by paragraph (2) (relating to the requirement on reporting of information to State boards) shall take effect on the date of the enactment of this Act.

SEC. 8455. HEALTH MAINTENANCE ORGANIZATIONS.

(a) **ADJUSTMENT IN MEDICARE CAPITATION PAYMENTS TO TAKE INTO ACCOUNT SECONDARY PAYER STATUS.**—

(1) **IN GENERAL.**—In defining the classes to be used in determining the annual per capita rate of payment under section 1876(a)(1)(B) of the Social Security Act to an eligible organization with a risk-sharing contract under such section (for contract years beginning on or after October 1, 1994), the Secretary of Health and Human Services shall treat as a separate class individuals entitled to benefits under title XVIII of such Act with respect to whom there is a group health plan that is a primary plan (within the meaning of section 1862(b)(2)(A) of such Act).

(2) **DEADLINE FOR ANNOUNCEMENT OF RATES.**—Not later than September 1, 1994, the Secretary shall announce annual per capita rates of payment for eligible organizations described in paragraph (1) that take into account the separate treatment of individuals with respect to whom there is a group health plan that is a primary plan.

(b) **REVISIONS IN THE PAYMENT METHODOLOGY FOR RISK CONTRACTORS.**—Section 4204(b) of OBRA-1990 is amended to read as follows:

“(b) **REVISIONS IN THE PAYMENT METHODOLOGY FOR RISK CONTRACTORS.**—(1)(A) Not later than October 1, 1995, the Secretary of Health and Human Services (in this subsection referred to as the ‘Secretary’) shall submit a proposal to the Congress that provides for revisions to the payment method to be applied in years beginning with 1996 for organizations with a risk-sharing contract under section 1876(g) of the Social Security Act.

“(B) In proposing the revisions required under subparagraph (A), the Secretary shall consider—

“(i) the difference in costs associated with medicare beneficiaries with differing health status and demographic characteristics; and

“(ii) the effects of using alternative geographic classifications on the determinations of costs associated with beneficiaries residing in different areas.

“(2) Not later than 3 months after the date of submittal of the proposal under paragraph (1), the Comptroller General shall review the proposal and shall report to Congress on the appropriateness of the proposed modifications.”.

(c) MISCELLANEOUS AND TECHNICAL CORRECTIONS.—(1) Section 1876(a)(3) (42 U.S.C. 1395mm(a)(3)) is amended by striking “subsection (c)(7)” and inserting “subsections (c)(2)(B)(ii) and (c)(7)”.

(2) Section 4204(c)(3) of OBRA-1990 is amended by striking “for 1991” and inserting “for years beginning with 1991”.

(3) Section 4204(d)(2) of OBRA-1990 is amended by striking “amendment” and inserting “amendments”.

(4) Section 1876(a)(1)(E)(ii)(I) (42 U.S.C. 1395mm(a)(1)(E)(ii)(I)) is amended by striking the comma after “contributed to”.

(5) Section 4204(e)(2) of OBRA-1990 is amended by striking “(which has a risk-sharing contract under section 1876 of the Social Security Act)”.

(6) Section 4204(f)(4) of OBRA-1990 is amended by striking “final”.

(7) Section 1862(b)(3)(C) (42 U.S.C. 1395y(b)(3)(C)) is amended—

(A) in the heading, by striking “PLAN” and inserting “PLAN OR A LARGE GROUP HEALTH PLAN”;

(B) by striking “group health plan” and inserting “group health plan or a large group health plan”;

(C) by striking “, unless such incentive is also offered to all individuals who are eligible for coverage under the plan”; and

(D) by striking “the first sentence of subsection (a) and other than subsection (b)” and inserting “subsections (a) and (b)”.

(8) The amendments made by this subsection shall take effect as if included in the enactment of OBRA-1990.

SEC. 8456. HOME HEALTH AGENCIES.

(a) USE OF MOST CURRENT DATA IN DETERMINING WAGE INDEX.—

(1) IN GENERAL.—Section 1861(v)(1)(L)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by striking “as of such date to” and inserting “and determined using the survey of the most recent available wages and wage-related costs of”.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to cost reporting periods beginning on or after July 1, 1996.

(b) CLARIFICATION OF EXTENSION OF WAIVER OF LIABILITY.—

(1) IN GENERAL.—The second sentence of section 9205 of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended by striking “November 1, 1990” and inserting “December 31, 1995”.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect as if included in the enactment of OBRA-1990.

SEC. 8457. PERMANENT EXTENSION OF AUTHORITY TO CONTRACT WITH FISCAL INTERMEDIARIES AND CARRIERS ON OTHER THAN A COST BASIS.

(a) IN GENERAL.—Section 2326(a) of the Deficit Reduction Act of 1984, as amended by section 6215 of OBRA-1989, is amended in the third sentence by striking “during such period” and inserting “beginning with fiscal year 1990 and any subsequent fiscal year”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

SEC. 8458. TRANSPORTATION DEMONSTRATION PROJECT.

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a demonstration project at 2 sites to—

(1) examine methods to reduce the cost of non-emergency medical transportation and regularly scheduled medical transportation by coordinating the timing of the provision of non-emergency medical services with the availability of public transportation; and

(2) examine methods to reduce the cost of emergency medical transportation and emergency room treatment through the supervised use of ambulance emergency medical technicians.

(b) SELECTION OF SITES.—Of the 2 sites selected for the demonstration project under subsection (a), one shall be in an urban area and one shall be in a rural area.

SEC. 8459. DIABETES TREATMENT DEMONSTRATION PROJECT.

The Secretary of Health and Human Services conduct a demonstration project at sites in urban and rural areas under which the Secretary shall provide for coverage under the medicare program of comprehensive diabetes treatment, management, and education services (including services necessary to provide intensive metabolic management found effective by the Diabetes Control and Complications Trial of the National Institutes of Health) to determine whether the manner in which payment is made for the treatment of diabetes under the medicare program should be modified.

SEC. 8460. EXPANSION OF NUMBER OF SITES FOR DEMONSTRATION PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE).

Section 9412(b)(1) of the Omnibus Budget Reconciliation Act of 1986 is amended by striking "not more than 15" and inserting "not more than 30".

SEC. 8460A. MISCELLANEOUS AND TECHNICAL CORRECTIONS.

(a) **SURVEY AND CERTIFICATION REQUIREMENTS.**—(1) Section 1864 (42 U.S.C. 1395aa) is amended—

(A) in subsection (e), by striking "title" and inserting "title (other than any fee relating to section 353 of the Public Health Service Act)"; and

(B) in the first sentence of subsection (a), by striking "1861(s) or" and all that follows through "Service Act," and inserting "1861(s)".

(2) An agreement made by the Secretary of Health and Human Services with a State under section 1864(a) of the Social Security Act may include an agreement that the services of the State health agency or other appropriate State agency (or the appropriate local agencies) will be utilized by the Secretary for the purpose of determining whether a laboratory meets the requirements of section 353 of the Public Health Service Act.

(b) **HOME DIALYSIS DEMONSTRATION TECHNICAL CORRECTIONS.**—Section 4202 of OBRA-1990 is amended—

(1) in subsection (b)(1)(A), by striking "home hemodialysis staff assistant" and inserting "qualified home hemodialysis staff assistant (as described in subsection (d))";

(2) in subsection (b)(2)(B)(ii)(I), by striking "(as adjusted to reflect differences in area wage levels)";

(3) in subsection (c)(1)(A), by striking "skilled"; and

(4) in subsection (c)(1)(E), by striking "(b)(4)" and inserting "(b)(2)".

(c) **TECHNICAL CORRECTION TO REVISIONS OF COVERAGE FOR IMMUNOSUPPRESSIVE DRUG THERAPY.**—

(1) **IN GENERAL.**—Section 1861(s)(2)(J) (42 U.S.C. 1395x(s)(2)(J)), as amended by section 13565 of OBRA-1993, is amended—

(A) by redesignating clauses (ii) through (v) as clauses (iii) through (vi); and

(B) by striking clause (i) and inserting the following:

"(i) before 1994, within 12 months after the date of the transplant procedure,

"(ii) to an individual who receives a transplant during 1994, within 487 days after the date of the transplant procedure,".

(2) **ADMINISTRATION OF BENEFIT.**—The Secretary of Health and Human Services may administer section 1861(s)(2)(J) of the Social Security Act (as amended by paragraph (1)) in a manner such that the months of coverage of drugs described in such section are provided consecutively, so long as the total number of months of coverage provided is the same as the number described in such section.

(d) **OTHER MISCELLANEOUS AND TECHNICAL PROVISIONS.**—(1) Section 1833 (42 U.S.C. 1395l) is amended by redesignating the subsection (r) added by section 4206(b)(2) of OBRA-1990 as subsection (s).

(2) Section 1866(f)(1) (42 U.S.C. 1395cc(f)(1)) is amended by striking "1833(r)" and inserting "1833(s)".

(3) Section 4201(d)(2) of OBRA-1990 is amended by striking "(B) by striking", "(C) by striking", and "(3) by adding" and inserting "(i) by striking", "(ii) by striking", and "(B) by adding", respectively.

(4) The section following section 4206 of OBRA-1990 is amended by striking "SEC. 4027." and inserting "SEC. 4207.", and in this subtitle is referred to as section 4207 of OBRA-1990.

(5)(A) Section 4207(a)(1) of OBRA-1990 is amended by adding closing quotation marks and a period after "such review."

(B) Section 4207(a)(4) of OBRA-1990 is amended by striking "this subsection" and inserting "paragraphs (2) and (3)".

(C) Section 4207(b)(1) of OBRA-1990 is amended by striking "section 3(7)" and inserting "section 601(a)(1)".

(6) Section 2355(b)(1)(B) of the Deficit Reduction Act of 1984, as amended by section 4207(b)(4)(B)(ii) of OBRA-1990, is amended—

(A) by striking "12907(c)(4)(A)" and inserting "4207(b)(4)(B)(i)", and

(B) by striking "feasibilitly" and inserting "feasibility".

(7) Section 4207(b)(4)(B)(iii)(III) of OBRA-1990 is amended by striking the period at the end and inserting a semicolon.

(8) Subsections (c)(3) and (e) of section 2355 of the Deficit Reduction Act of 1984, as amended by section 4207(b)(4)(B) of OBRA-1990, are each amended by striking "12907(c)(4)(A)" each place it appears and inserting "4207(b)(4)(B)".

(9) Section 4207(c)(2) of OBRA-1990 is amended by striking "the Committee on Ways and Means" each place it appears and inserting "the Committees on Ways and Means and Energy and Commerce".

(10) Section 4207(d) of OBRA-1990 is amended by redesignating the second paragraph (3) (relating to effective date) as paragraph (4).

(11) Section 4207(i)(2) of OBRA-1990 is amended—

(A) by striking the period at the end of clause (iii) and inserting a semicolon, and

(B) in clause (v), by striking "residents" and inserting "patients".

(12) Section 4207(j) of OBRA-1990 is amended by striking "title" each place it appears and inserting "subtitle".

PART 4—PROVISIONS RELATING TO MEDICARE SUPPLEMENTAL INSURANCE POLICIES

SEC. 8461. STANDARDS FOR MEDICARE SUPPLEMENTAL INSURANCE POLICIES.

(a) SIMPLIFICATION OF MEDICARE SUPPLEMENTAL POLICIES.—

(1) Section 4351 of OBRA-1990 is amended by striking "(a) IN GENERAL.—".

(2) Section 1882(p) (42 U.S.C. 1395ss(p)) is amended—

(A) in paragraph (1)(A)—

(i) by striking "promulgates" and inserting "changes the revised NAIC Model Regulation (described in subsection (m)) to incorporate",

(ii) by striking "(such limitations, language, definitions, format, and standards referred to collectively in this subsection as 'NAIC standards')", and

(iii) by striking "included a reference to the NAIC standards" and inserting "were a reference to the revised NAIC Model Regulation as changed under this subparagraph (such changed regulation referred to in this section as the '1991 NAIC Model Regulation')";

(B) in paragraph (1)(B)—

(i) by striking "promulgate NAIC standards" and inserting "make the changes in the revised NAIC Model Regulation",

(ii) by striking "limitations, language, definitions, format, and standards described in clauses (i) through (iv) of such subparagraph (in this subsection referred to collectively as 'Federal standards')" and inserting "a regulation", and

(iii) by striking "included a reference to the Federal standards" and inserting "were a reference to the revised NAIC Model Regulation as changed by the Secretary under this subparagraph (such changed regulation referred to in this section as the '1991 Federal Regulation')";

(C) in paragraph (1)(C)(i), by striking "NAIC standards or the Federal standards" and inserting "1991 NAIC Model Regulation or 1991 Federal Regulation";

(D) in paragraphs (1)(C)(ii)(I), (1)(E), (2), and (9)(B), by striking "NAIC or Federal standards" and inserting "1991 NAIC Model Regulation or 1991 Federal Regulation";

(E) in paragraph (2)(C), by striking "(5)(B)" and inserting "(4)(B)";

(F) in paragraph (4)(A)(i), by inserting "or paragraph (6)" after "(B)";

(G) in paragraph (4), by striking "applicable standards" each place it appears and inserting "applicable 1991 NAIC Model Regulation or 1991 Federal Regulation";

(H) in paragraph (6), by striking "in regard to the limitation of benefits described in paragraph (4)" and inserting "described in clauses (i) through (iii) of paragraph (1)(A)";

(I) in paragraph (7), by striking "policyholder" and inserting "policyholders";

(J) in paragraph (8), by striking "after the effective date of the NAIC or Federal standards with respect to the policy, in violation of the previous requirements of this subsection" and inserting "on and after the effective date specified in paragraph (1)(C) (but subject to paragraph (10)), in violation of the applicable 1991 NAIC Model Regulation or 1991 Federal Regulation insofar as such regulation relates to the requirements of subsection (o) or (q) or clause (i), (ii), or (iii) of paragraph (1)(A)";

(K) in paragraph (9), by adding at the end the following new subparagraph:

“(D) Subject to paragraph (10), this paragraph shall apply to sales of policies occurring on or after the effective date specified in paragraph (1)(C).”; and

(L) in paragraph (10), by striking “this subsection” and inserting “paragraph (1)(A)(i)”.

(b) **GUARANTEED RENEWABILITY.**—Section 1882(q) (42 U.S.C. 1395ss(q)) is amended—

(1) in paragraph (2), by striking “paragraph (2)” and inserting “paragraph (4)”, and

(2) in paragraph (4), by striking “the succeeding issuer” and inserting “issuer of the replacement policy”.

(c) **ENFORCEMENT OF STANDARDS.**—

(1) Section 1882(a)(2) (42 U.S.C. 1395ss(a)(2)) is amended—

(A) in subparagraph (A), by striking “NAIC standards or the Federal standards” and inserting “1991 NAIC Model Regulation or 1991 Federal Regulation”, and

(B) by striking “after the effective date of the NAIC or Federal standards with respect to the policy” and inserting “on and after the effective date specified in subsection (p)(1)(C)”.

(2) The sentence in section 1882(b)(1) added by section 4353(c)(5) of OBRA-1990 is amended—

(A) by striking “The report” and inserting “Each report”,

(B) by inserting “and requirements” after “standards”,

(C) by striking “and” after “compliance,”, and

(D) by striking the comma after “Commissioners”.

(3) Section 1882(g)(2)(B) (42 U.S.C. 1395ss(g)(2)(B)) is amended by striking “Panel” and inserting “Secretary”.

(4) Section 1882(b)(1) (42 U.S.C. 1395ss(b)(1)) is amended by striking “the the Secretary” and inserting “the Secretary”.

(d) **PREVENTING DUPLICATION.**—

(1) Section 1882(d)(3)(A) (42 U.S.C. 1395ss(d)(3)(A)) is amended—

(A) by amending the first sentence to read as follows:

“(i) It is unlawful for a person to sell or issue to an individual entitled to benefits under part A or enrolled under part B of this title—

“(I) a health insurance policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under this title or title XIX,

“(II) a medicare supplemental policy with knowledge that the individual is entitled to benefits under another medicare supplemental policy, or

“(III) a health insurance policy (other than a medicare supplemental policy) with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled, other than benefits to which the individual is entitled under a requirement of State or Federal law.”;

(B) by designating the second sentence as clause (ii) and, in such clause, by striking “the previous sentence” and inserting “clause (i)”;

(C) by designating the third sentence as clause (iii) and, in such clause—

(i) by striking “the previous sentence” and inserting “clause (i) with respect to the sale of a medicare supplemental policy”, and

(ii) by striking “and the statement” and all that follows up to the period at the end; and

(D) by striking the last sentence.

(2) Section 1882(d)(3)(B) (42 U.S.C. 1395ss(d)(3)(B)) is amended—

(A) in clause (ii)(II), by striking “65 years of age or older”,

(B) in clause (iii)(I), by striking “another medicare” and inserting “a medicare”,

(C) in clause (iii)(I), by striking “such a policy” and inserting “a medicare supplemental policy”,

(D) in clause (iii)(II), by striking “another policy” and inserting “a medicare supplemental policy”, and

(E) by amending subclause (III) of clause (iii) to read as follows:

“(III) If the statement required by clause (i) is obtained and indicates that the individual is entitled to any medical assistance under title XIX, the sale of the policy is not in violation of clause (i) (insofar as such clause relates to such medical assistance), if (aa) a State medicaid plan under such title pays the premiums for the policy, (bb) in the case of a qualified medicare beneficiary described in section 1905(p)(1), the policy provides for coverage of outpatient prescription drugs, or (cc)

the only medical assistance to which the individual is entitled under the State plan is medicare cost sharing described in section 1905(p)(3)(A)(ii)."

(3)(A) Section 1882(d)(3)(C) (42 U.S.C. 1395ss(d)(3)(C)) is amended—

- (i) by striking "the selling" and inserting "(i) the sale or issuance", and
- (ii) by inserting before the period at the end the following: ", (ii) the sale or issuance of a policy or plan described in subparagraph (A)(i)(I) (other than a medicare supplemental policy to an individual entitled to any medical assistance under title XIX) under which all the benefits are fully payable directly to or on behalf of the individual without regard to other health benefit coverage of the individual but only if (for policies sold or issued more than 60 days after the date the statements are published or promulgated under subparagraph (D)) there is disclosed in a prominent manner as part of (or together with) the application the applicable statement (specified under subparagraph (D)) of the extent to which benefits payable under the policy or plan duplicate benefits under this title and (in the case of a policy that is not a health plan described in section 2203(c)(2) and does not provide coverage for benefits regardless of other coverage), to the extent considered appropriate by the Secretary, benefits under the guaranteed national benefit package under title XXI or under a standardized benefit package for supplemental health benefit policies established under part D of title XXII, or (iii) the sale or issuance of a policy or plan described in subparagraph (A)(i)(III) under which all the benefits are fully payable directly to or on behalf of the individual without regard to other health benefit coverage of the individual".

(B) Section 1882(d)(3) (42 U.S.C. 1395ss(d)(3)) is amended by adding at the end the following:

"(D)(i) If—

"(I) within the 90-day period beginning on the date of the enactment of this subparagraph, the National Association of Insurance Commissioners develops (after consultation with consumer and insurance industry representatives) and submits to the Secretary a statement for each of the types of health insurance policies (other than medicare supplemental policies and including, but not limited to, as separate types of policies, policies paying directly to the beneficiary fixed, cash benefits, and policies that limit benefit payments to specific diseases) which are sold or issued to persons entitled to health benefits under this title, of the extent to which benefits payable under the policy or plan duplicate benefits under this title, and

"(II) the Secretary approves all the statements submitted as meeting the requirements of subclause (I),
each such statement shall be (for purposes of subparagraph (C)) the statement specified under this subparagraph for the type of policy involved. The Secretary shall review and approve (or disapprove) all the statements submitted under subclause (I) within 30 days after the date of their submittal. Upon approval of such statements, the Secretary shall publish such statements.

"(ii) If the Secretary does not approve the statements under clause (i) or the statements are not submitted within the 90-day period specified in such clause, the Secretary shall promulgate (after consultation with consumer and insurance industry representatives and not later than 90 days after the date of disapproval or the end of such 90-day period (as the case may be)) a statement for each of the types of health insurance policies (other than medicare supplemental policies and including, but not limited to, as separate types of policies, policies paying directly to the beneficiary fixed, cash benefits, and policies that limit benefit payments to specific diseases) which are sold or issued to persons entitled to health benefits under this title, of the extent to which benefits payable under the policy or plan duplicate benefits under this title, and each such statement shall be (for purposes of subparagraph (C)) the statement specified under this subparagraph for the type of policy involved."

(C) The requirement of a disclosure under section 1882(d)(3)(C)(ii) of the Social Security Act shall not apply to an application made for a policy or plan before 60 days after the date the Secretary of Health and Human Services publishes or promulgates all the statements under section 1882(d)(3)(D) of such Act.

(4) Subparagraphs (A) and (B) of section 1882(q)(5) are amended by striking "of the Social Security Act".

(e) LOSS RATIOS AND REFUNDS OF PREMIUMS.—

(1) Section 1882(r) (42 U.S.C. 1395ss(r)) is amended—

- (A) in paragraph (1), by striking "or sold" and inserting "or renewed (or otherwise provide coverage after the date described in subsection (p)(1)(C))";
- (B) in paragraph (1)(A), by inserting "for periods after the effective date of these provisions" after "the policy can be expected";

(C) in paragraph (1)(A), by striking "Commissioners," and inserting "Commissioners");

(D) in paragraph (1)(B), by inserting before the period at the end the following: ", treating policies of the same type as a single policy for each standard package";

(E) by adding at the end of paragraph (1) the following: "For the purpose of calculating the refund or credit required under paragraph (1)(B) for a policy issued before the date specified in subsection (p)(1)(C), the refund or credit calculation shall be based on the aggregate benefits provided and premiums collected under all such policies issued by an insurer in a State (separated as to individual and group policies) and shall be based only on aggregate benefits provided and premiums collected under such policies after the date specified in section 8461(m)(4) of the Health Security Act.";

(F) in the first sentence of paragraph (2)(A), by striking "by policy number" and inserting "by standard package";

(G) by striking the second sentence of paragraph (2)(A) and inserting the following: "Paragraph (1)(B) shall not apply to a policy until 12 months following issue.";

(H) in the last sentence of paragraph (2)(A), by striking "in order" and all that follows through "are effective";

(I) by adding at the end of paragraph (2)(A), the following new sentence: "In the case of a policy issued before the date specified in subsection (p)(1)(C), paragraph (1)(B) shall not apply until 1 year after the date specified in section 8461(m)(4) of the Health Security Act.";

(J) in paragraph (2), by striking "policy year" each place it appears and inserting "calendar year";

(K) in paragraph (4), by striking "February", "disallowance", "loss-ratios" each place it appears, and "loss-ratio" and inserting "October", "disallowance", "loss ratios", and "loss ratio", respectively;

(L) in paragraph (6)(A), by striking "issues a policy in violation of the loss ratio requirements of this subsection" and "such violation" and inserting "fails to provide refunds or credits as required in paragraph (1)(B)" and "policy issued for which such failure occurred", respectively; and

(M) in paragraph (6)(B), by striking "to policyholders" and inserting "to the policyholder or, in the case of a group policy, to the certificate holder".

(2) Section 1882(b)(1) (42 U.S.C. 1395ss(b)(1)) is amended, in the matter after subparagraph (H), by striking "subsection (F)" and inserting "subparagraph (F)".

(3) Section 4355(d) of OBRA-1990 is amended by striking "sold or issued" and all that follows and inserting "issued or renewed (or otherwise providing coverage after the date described in section 1882(p)(1)(C) of the Social Security Act) on or after the date specified in section 1882(p)(1)(C) of the Social Security Act."

(f) TREATMENT OF HMO'S.—

(1) Section 1882(g)(1) (42 U.S.C. 1395ss(g)(1)) is amended by striking "a health maintenance organization or other direct service organization" and all that follows through "1833" and inserting "an eligible organization (as defined in section 1876(b)) if the policy or plan provides benefits pursuant to a contract under section 1876 or an approved demonstration project described in section 603(c) of the Social Security Amendments of 1983, section 2355 of the Deficit Reduction Act of 1984, or section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, or, during the period beginning on the date specified in subsection (p)(1)(C) and ending on December 31, 1994, a policy or plan of an organization if the policy or plan provides benefits pursuant to an agreement under section 1833(a)(1)(A)".

(2) Section 4356(b) of OBRA-1990 is amended by striking "on the date of the enactment of this Act" and inserting "on the date specified in section 1882(p)(1)(C) of the Social Security Act".

(g) PRE-EXISTING CONDITION LIMITATIONS.—Section 1882(s) (42 U.S.C. 1395ss(s)) is amended—

(1) in paragraph (2)(A), by striking "for which an application is submitted" and inserting "in the case of an individual for whom an application is submitted prior to or",

(2) in paragraph (2)(A), by striking "in which the individual (who is 65 years of age or older) first is enrolled for benefits under part B" and inserting "as of the first day on which the individual is 65 years of age or older and is enrolled for benefits under part B", and

- (3) in paragraph (2)(B), by striking “before it” and inserting “before the policy”.
- (h) **MEDICARE SELECT POLICIES.**—
- (1) Section 1882(t) (42 U.S.C. 1395ss(t)) is amended—
- (A) in paragraph (1), by inserting “medicare supplemental” after “If a”,
- (B) in paragraph (1), by striking “NAIC Model Standards” and inserting “1991 NAIC Model Regulation or 1991 Federal Regulation”,
- (C) in paragraph (1)(A), by inserting “or agreements” after “contracts”,
- (D) in subparagraphs (E)(i) and (F) of paragraph (1), by striking “NAIC standards” and inserting “standards in the 1991 NAIC Model Regulation or 1991 Federal Regulation”, and
- (E) in paragraph (2), by inserting “the issuer” before “is subject to a civil money penalty”.
- (2) Section 1154(a)(4)(B) (42 U.S.C. 1320c-3(a)(4)(B)) is amended—
- (A) by inserting “that is” after “(or”, and
- (B) by striking “1882(t)” and inserting “1882(t)(3)”.
- (i) **HEALTH INSURANCE COUNSELING.**—Section 4360 of OBRA-1990 is amended—
- (1) in subsection (b)(2)(A)(ii), by striking “Act” and inserting “Act”;
- (2) in subsection (b)(2)(D), by striking “services” and inserting “counseling”;
- (3) in subsection (b)(2)(I), by striking “assistance” and inserting “referrals”;
- (4) in subsection (c)(1), by striking “and that such activities will continue to be maintained at such level”;
- (5) in subsection (d)(3), by striking “to the rural areas” and inserting “eligible individuals residing in rural areas”;
- (6) in subsection (e)—
- (A) by striking “subsection (c) or (d)” and inserting “this section”,
- (B) by striking “and annually thereafter, issue an annual report” and inserting “and annually thereafter during the period of the grant, issue a report”, and
- (C) in paragraph (1), by striking “State-wide”;
- (7) in subsection (f), by striking paragraph (2) and by redesignating paragraphs (3) through (5) as paragraphs (2) through (4), respectively; and
- (8) in the second subsection (f) (relating to authorization of appropriations for grants)—
- (A) by striking “and 1993” and inserting “1993, 1994, 1995, and 1996”; and
- (B) by redesignating such subsection as subsection (g).
- (j) **TELEPHONE INFORMATION SYSTEM.**—
- (1) Section 1804 (42 U.S.C. 1395b-2) is amended—
- (A) by adding at the end of the heading the following: “; MEDICARE AND MEDIGAP INFORMATION”;
- (B) by inserting “(a)” after “1804.”, and
- (C) by adding at the end the following new subsection:
- “(b) The Secretary shall provide information via a toll-free telephone number on the programs under this title.”
- (2) Section 1882(f) (42 U.S.C. 1395ss(f)) is amended by adding at the end the following new paragraph:
- “(3) The Secretary shall provide information via a toll-free telephone number on medicare supplemental policies (including the relationship of State programs under title XIX to such policies).”
- (3) Section 1889 is repealed.
- (k) **MAILING OF POLICIES.**—Section 1882(d)(4) (42 U.S.C. 1395ss(d)(4)) is amended—
- (1) in subparagraph (D), by striking “, if such policy” and all that follows up to the period at the end, and
- (2) by adding at the end the following new subparagraph:
- “(E) Subparagraph (A) shall not apply in the case of an issuer who mails or causes to be mailed a policy, certificate, or other matter solely to comply with the requirements of subsection (q).”
- (l) **EFFECTIVE DATE.**—The amendments made by this section shall be effective as if included in the enactment of OBRA-1990; except that—
- (1) the amendments made by subsection (d)(1) shall take effect on the date of the enactment of this Act, but no penalty shall be imposed under section 1882(d)(3)(A) of the Social Security Act (for an action occurring after the effective date of the amendments made by section 4354 of OBRA-1990 and before the date of the enactment of this Act) with respect to the sale or issuance of a policy which is not unlawful under section 1882(d)(3)(A)(i)(II) of the Social Security Act (as amended by this section);

(2) the amendments made by subsection (d)(2)(A) and by subparagraphs (A), (B), and (E) of subsection (e)(1) shall be effective on the date specified in subsection (m)(4); and

(3) the amendment made by subsection (g)(2) shall take effect on January 1, 1995, and shall apply to individuals who attain 65 years of age or older on or after the effective date of section 1882(s)(2) of the Social Security Act (and, in the case of individuals who attained 65 years of age after such effective date and before January 1, 1995, and who were not covered under such section before January 1, 1995, the 6-month period specified in that section shall begin January 1, 1995).

(m) TRANSITION PROVISIONS.—

(1) IN GENERAL.—If the Secretary of Health and Human Services identifies a State as requiring a change to its statutes or regulations to conform its regulatory program to the changes made by this section, the State regulatory program shall not be considered to be out of compliance with the requirements of section 1882 of the Social Security Act due solely to failure to make such change until the date specified in paragraph (4).

(2) NAIC STANDARDS.—If, within 6 months after the date of the enactment of this Act, the National Association of Insurance Commissioners (in this subsection referred to as the “NAIC”) modifies its 1991 NAIC Model Regulation (adopted in July 1991) to conform to the amendments made by this section and to delete from section 15C the exception which begins with “unless”, such revised regulation incorporating the modifications shall be considered to be the 1991 Regulation for the purposes of section 1882 of the Social Security Act.

(3) SECRETARY STANDARDS.—If the NAIC does not make the modifications described in paragraph (2) within the period specified in such paragraph, the Secretary of Health and Human Services shall make the modifications described in such paragraph and such revised regulation incorporating the modifications shall be considered to be the 1991 Regulation for the purposes of section 1882 of the Social Security Act.

(4) DATE SPECIFIED.—

(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

- (i) the date the State changes its statutes or regulations to conform its regulatory program to the changes made by this section, or
- (ii) 1 year after the date the NAIC or the Secretary first makes the modifications under paragraph (2) or (3), respectively.

(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies as—

- (i) requiring State legislation (other than legislation appropriating funds) to conform its regulatory program to the changes made in this section, but
- (ii) having a legislature which is not scheduled to meet in 1996 in a legislative session in which such legislation may be considered, the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1996. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

TITLE IX—QUALITY AND CONSUMER PROTECTION

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Subtitle A—Quality Management and Improvement

PART 1—NATIONAL QUALITY MANAGEMENT PROGRAM

SEC. 9001. NATIONAL QUALITY MANAGEMENT PROGRAM.

(a) **ESTABLISHMENT.**—The Secretary shall establish and oversee a performance-based program of quality management and improvement designed to enhance the quality, appropriateness, and effectiveness of health care services rendered in the United States. The program shall be known as the National Quality Management Program.

(b) **ELEMENTS.**—Subject to the specific provisions of this part, the National Quality Management Program shall consist of the following:

- (1) The consumer surveys described in section 9002.
- (2) The national measures of quality performance described in section 9003.
- (3) The methodologies for profiling health care providers and the methods and standards for improving quality of care described in section 9004.
- (4) The quality-related profiling data described in section 9005.
- (5) The national quality standards for private plan sponsors described in section 9006.
- (6) The compliance monitoring described in section 9007.
- (7) The guideline development and certification and the research on health care quality described in section 9008.
- (8) The contracts with approved quality improvement organizations entered into by the Secretary under section 9009.
- (9) The quality management grants made to approved States by the Secretary under section 9010.

SEC. 9002. CONSUMER SURVEYS.

(a) **IN GENERAL.**—Private plan sponsors and health institutions shall conduct annual surveys of health care consumers to gather information concerning access to care, use of health services, health outcomes, and patient satisfaction. The surveys shall be conducted using the standard design and the sampling strategies developed under subsection (c).

(b) **TRANSMISSION OF SURVEY RESULTS.**—

(1) **PLAN SPONSORS.**—A private plan sponsor shall forward the results of any survey conducted under this section that pertains to a private health benefit plan provided or sponsored by the sponsor in a State to—

(A) the State (if the State is an approved State); and

(B) the approved quality improvement organization responsible for the geographic area that includes the State.

(2) **HEALTH CARE INSTITUTIONS.**—A health institution shall forward the results of any survey conducted under this section that pertains to health care services rendered in a State by the institution to—

(A) the State (if the State is an approved State); and

(B) the approved quality improvement organization responsible for the geographic area that includes the State.

(c) SECRETARIAL RESPONSIBILITIES.—

(1) STANDARD DESIGN.—The Secretary shall develop and approve a standard design for the surveys conducted under subsection (a). The design shall ensure the collection of valid, reliable, and comparable survey responses.

(2) SAMPLING STRATEGIES.—The Secretary shall develop sampling strategies that ensure that survey samples adequately measure populations that are considered to be at risk of receiving inadequate health care.

(3) DEADLINE.—The Secretary shall develop and approve the design under paragraph (1) and the sampling strategies under paragraph (2) not later than 12 months after the date of the enactment of this Act.

SEC. 9003. NATIONAL MEASURES OF QUALITY PERFORMANCE.

(a) DEVELOPMENT AND UPDATING.—

(1) IN GENERAL.—The Secretary shall develop and update a uniform set of national measures of quality performance to be used to assess—

(A) the performance of private plan sponsors and health institutions;

(B) the satisfaction of individuals enrolled under a private health benefit plan with the services provided by the private plan sponsor providing or sponsoring the plan;

(C) the satisfaction of individuals receiving items and services from a health institution; and

(D) the effect of the receipt of the items and services described in subparagraphs (B) and (C) on the health status of the individuals described in such subparagraphs.

(2) MINIMUM INFORMATION REQUIRED TO BE PROVIDED.—The measures shall be developed and selected in a manner that ensures that private plan sponsors and health institutions are required to provide the minimum amount of information that is necessary to perform the assessments referred to in paragraph (1).

(3) BASES FOR MEASURES.—In developing and selecting the national measures of quality performance, the Secretary shall consider the recommendations of the Health Care Quality Advisory Commission established under section 9012 (in this subtitle referred to as the “Commission”). The measures also may be based on guidelines developed or certified by the Administrator for Health Care Policy and Research under section 9008, research sponsored by the Administrator under such section, or other guidelines or research, if the guidelines or research are determined to be appropriate for such purpose by the Secretary.

(4) SEQUENTIAL SETS.—The set of national measures of quality performance shall be established through the development and use of a series of interim sets of quality measures. The Secretary, in consultation with the Commission, shall establish a sequence for such sets. The initial set of national measures of quality performance shall provide data on access to care and, with respect to a private plan sponsor, data on the number, types, and locations of health care providers who are authorized to provide services or receive payments under each private health benefit plan provided or sponsored by the sponsor. Subsequent sets of measures shall provide additional data as such data becomes valid and available (as determined by the Secretary).

(b) SUBJECT OF MEASURES.—The national measures of quality performance shall be selected in a manner that provides accurate, comparable information on the following subjects:

(A) Access to health care services and procedures by individuals enrolled in private health benefit plans.

(B) Outcomes, effectiveness, and appropriateness of such health care services and procedures.

(C) Patient functional status.

(D) Risk management and reduction, through screening, education, and health promotion, aimed at reducing the risk that such individuals will develop diseases, disorders, or other adverse health conditions.

(E) Consumer experience and satisfaction.

(c) CRITERIA.—The following criteria shall be used in developing and selecting national measures of quality performance:

(1) SIGNIFICANCE.—When a measure relates to a specific disease, disorder, or other health condition, the disease, disorder, or condition shall be of significance in terms of prevalence, morbidity, mortality, or the costs associated with the prevention, diagnosis, treatment, or clinical management of the disease, disorder, or condition.

(2) **RANGE OF SERVICES.**—The set of measures, taken as a whole, shall be representative of the range of services provided to consumers of health care.

(3) **RELIABILITY AND VALIDITY.**—The measures shall be reliable and valid.

(4) **UNDUE BURDEN.**—The data needed to calculate the measures shall be obtained without undue burden on the entity or individual providing the data.

(5) **RURAL PRACTICE.**—The measures shall take into account criteria appropriate to rural clinical practice.

(6) **VARIATION.**—Performance with respect to a measure shall be expected to vary widely among the individuals and entities whose performance is assessed using the measure.

(7) **LINKAGE TO HEALTH OUTCOME.**—When a measure is established relating to a process of care, the process shall be linked to a health outcome based upon the best available scientific evidence.

(8) **PROVIDER CONTROL AND RISK ADJUSTMENT.**—When a measure is an outcome of the provision of care, the outcome shall be within the control of the provider and one with respect to which an adequate risk adjustment can be made.

(9) **PUBLIC HEALTH.**—The measures may incorporate standards identified by the Secretary for meeting public health objectives.

(d) **DATA TRANSMISSION.**—

(1) **PLAN SPONSORS.**—A private plan sponsor shall transmit the data determined by the Secretary to be necessary to assess the performance of the sponsor under this section with respect to a private health benefit plan provided or sponsored by the sponsor in a State to—

(A) the State (if the State is an approved State); and

(B) the approved quality improvement organization responsible for the geographic area that includes the State.

(2) **HEALTH INSTITUTIONS.**—A health institution shall transmit the data determined by the Secretary to be necessary to assess the performance of the institution under this section with respect to health care services rendered in a State by the institution to—

(A) the State (if the State is an approved State); and

(B) the approved quality improvement organization responsible for the geographic area that includes the State.

(e) **DATA VALIDATION.**—The approved quality improvement organization responsible for the geographic area that includes a State, in consultation with the State, shall conduct such audits of the data submitted to the organization and the State under subsection (d) as are necessary to ensure that the data are valid, reliable, and complete. A private plan sponsor and a health institution shall maintain such records, make such reports, and cooperate with the audits to the extent necessary to permit a quality improvement organization to satisfy the preceding sentence.

(f) **ASSESSMENT OF PERFORMANCE.**—

(1) **STATES.**—Each approved State annually shall assess the performance of each private plan sponsor providing or sponsoring a private health benefit plan in the State and each health institution licensed by the State using the national measures of quality performance.

(2) **PLAN SPONSORS.**—A private plan sponsor shall use the national measures of quality performance to assess—

(A) the satisfaction of individuals enrolled under a private health benefit plan provided or sponsored by the sponsor with the services of the sponsor; and

(B) the effect of such services on the health status of such individuals.

(g) **PERFORMANCE REPORTS.**—

(1) **APPROVED STATES.**—Using a standard format prescribed by the Secretary, and not later than January 1 of each year, an approved State shall compile in the form of a performance report the results of assessments conducted by the State under subsection (f), the results of the consumer surveys conducted under section 9002 by private plan sponsors providing or sponsoring a private health benefit plan in the State and health institutions licensed by the State, and any other relevant information concerning such sponsors with respect to the national quality standards under section 9006. The report shall be written in language calculated to be understood by the typical individual enrolled under a private health benefit plan and in a form which will assist consumers in selecting among such plans. The State shall transmit the performance report to the approved quality improvement organization for the geographic area established under section 9009(d) in which the State is located.

(2) **QUALITY IMPROVEMENT ORGANIZATIONS.**—Each approved quality improvement organization annually shall publish and make available to the public each performance report transmitted under paragraph (1) by an approved State that

is located in the geographic area for which the organization is responsible pursuant to section 9009. An approved quality improvement organization shall transmit a copy of any report published pursuant to this paragraph to the Secretary. The Secretary shall compile such reports for the Congress.

(h) DEADLINE.—The Secretary shall develop an initial set of national measures of quality performance and the standard format for the performance reports under subsection (g) not later than 12 months after the date of the enactment of this Act.

SEC. 9004. PROFILING PATTERNS OF PRACTICE OF HEALTH CARE PROVIDERS.

(a) PROFILING OF PATTERNS OF PRACTICE; OPPORTUNITIES FOR QUALITY IMPROVEMENT.—

(1) METHODOLOGY ADOPTION.—The Secretary shall adopt methodologies for profiling the patterns of clinical practice of health care providers and private plan sponsors (to the extent that such sponsors provide health care services) and for identifying outliers (as defined in paragraph (5)).

(2) DISSEMINATION.—The Secretary shall disseminate to approved quality improvement organizations, private plan sponsors, and approved States the methodologies adopted under paragraph (1).

(3) OPPORTUNITIES FOR QUALITY IMPROVEMENT.—The Secretary shall develop and disseminate to approved quality improvement organizations methods and standards for improving quality of care where opportunities are identified through profiling and other means so as to assure the quality of health care services provided in the United States.

(4) DEADLINE.—The Secretary shall adopt the methodologies and develop the standards under this subsection not later than 12 months after the date of the enactment of this Act.

(5) OUTLIER DEFINED.—In this subtitle, the term “outlier” means a health care provider whose pattern of practice suggests deficiencies in the quality of health care services being provided by the provider.

(b) IMPLEMENTATION BY QUALITY IMPROVEMENT ORGANIZATIONS.—

(1) IN GENERAL.—An approved quality improvement organization shall implement, on an ongoing basis, the methodologies adopted and the methods and standards established under subsection (a) with respect to health care providers who are licensed by a State that is in a geographic area for which the organization is responsible. The duties of an approved quality improvement organization under the preceding sentence shall include population-based monitoring of the patterns of clinical practice described in subsection (a)(1) for the purpose of promoting community-based quality improvement.

(2) USE OF GUIDELINES.—An approved quality improvement organization shall integrate into local practice of medicine guidelines developed, updated, or certified pursuant to section 9008 or other guidelines to carry out paragraph (1).

(c) ENFORCEMENT.—If an approved quality improvement organization finds, after affording reasonable opportunities for improvement, that a health care provider who has been identified by the organization as an outlier fails to engage in quality improvement activities or continues to furnish services of poor technical quality, the organization shall notify the appropriate Federal and State board or boards responsible for licensing, accrediting, and disciplining the provider.

SEC. 9005. QUALITY-RELATED PROFILING DATA.

(a) TRANSMISSION.—

(1) PLANS.—A private plan sponsor shall transmit to each approved quality improvement organization for a geographic area that includes a State in which the sponsor provides or sponsors a private health benefit plan the set of quality-related profiling data established by the Secretary under subsection (b) using the electronic format established under subsection (c).

(2) PROVIDERS.—A health care provider shall transmit to each approved quality improvement organization for a geographic area that includes a State in which the provider is licensed the set of quality-related profiling data established by the Secretary under subsection (b) using the electronic format established under subsection (c).

(b) ESTABLISHMENT OF DATA SETS.—

(1) IN GENERAL.—The Secretary shall establish a set of quality-related profiling data to be transmitted by private plan sponsors and health care providers to approved quality improvement organizations in order to permit such organizations to carry out section 9004(b). The Secretary shall also specify the frequency with which private plan sponsors and health care providers are required to transmit the quality-related profiling data set.

(2) NO UNDUE BURDEN.—With respect to data developed or collected by a private plan sponsor or a health care provider under this section, the Secretary

shall, in order to assure the utility, accuracy, and sufficiency of such data, establish guidelines for uniform methods of developing and collecting such data. Such guidelines shall include specifications ensuring that any set of quality-related profiling data to be transmitted under this section may be developed or collected using the least burdensome method consistent with the efficient and effective administration of this part.

(c) **UNIFORM ELECTRONIC FORMAT.**—The Secretary shall develop a uniform electronic format that specifies the form and manner in which private plan sponsors and health care providers are required to transmit data under this section. Such format shall be developed consistent with the requirements for formatting electronic data established under subtitle B.

(d) **USE AND DISCLOSURE OF DATA.**—The Secretary shall establish standards concerning the purposes for which, and the procedures by which, data that is transmitted to, and collected by, an approved quality improvement organization under this section may be used and disclosed by the State or organization. The standards established under this subsection shall be consistent with the standards established under subsection (e).

(e) **PRIVACY.**—The Secretary shall establish standards that are consistent with part 4 to protect the privacy of protected health information (as defined in part 4) that is transmitted to, and collected by, an approved quality improvement organization under this section. Such standards shall include standards regarding the aggregation of data in a manner that does not reveal data that identifies or can readily be associated with the identity of an individual.

(f) **REQUIREMENT ON STATES.**—An approved State shall enforce the requirements of this section with respect to each private plan sponsor that provides or sponsors a private health benefit plan in the State and each health care provider licensed by the State.

(g) **REQUIREMENT ON ORGANIZATIONS.**—An approved quality improvement organization shall comply with the standards established by the Secretary under subsections (d) and (e).

(h) **LIMITATION ON LIABILITY.**—Notwithstanding any other provision of law, a person providing information to any approved quality improvement organization under this section may not be held, by reason of having provided such information, to have violated any criminal law, or to be civilly liable under any law of the United States or of any State (or political subdivision thereof) unless—

(1) such information is unrelated to the performance of the contract of such organization with the Secretary under section 9009; or

(2) such information is false and the person providing it knew, or had reason to believe, that such information was false.

(i) **DEADLINE.**—Not later than 12 months after the date of the enactment of this Act, the Secretary—

(1) shall establish the set of quality-related profiling data under subsection (b);

(2) shall develop the uniform electronic format under subsection (c); and

(3) shall establish the standards under subsections (d) and (e).

SEC. 9006. NATIONAL QUALITY STANDARDS FOR PRIVATE PLAN SPONSORS.

(a) **IN GENERAL.**—Not later than 12 months after the date of the enactment of this Act, the Secretary shall establish national quality standards for private plan sponsors. The standards established by the Secretary shall include the standards described in subsections (b) and (c).

(b) **REQUIREMENTS FOR PRIVATE PLAN SPONSORS.**—The quality standards for private plan sponsors shall require each such sponsor—

(1) to establish an internal quality improvement program and, through such program, cooperate with the performance monitoring activities undertaken by approved States under section 9007;

(2) to make available to individuals enrolled in a private health benefit plan provided or sponsored by the sponsor information about the rights and responsibilities of enrollees;

(3) to provide an appeals procedure for review of benefit determinations that satisfies the requirements of part 2;

(4) to provide a grievance procedure that provides for effective and timely response to complaints for enrollees to use in pursuing complaints with respect to the sponsor that are not based on a benefit determination reviewable under part 2;

(5) to establish procedures for taking appropriate remedial action whenever inappropriate or substandard services are provided by an officer or employee of

the sponsor or a health care provider who is a participating provider in a private health benefit plan provided or sponsored by the sponsor;

(6) to verify the credentials of health care providers who are participating providers in a private health benefit plan provided or sponsored by the sponsor;

(7) to establish a policy to identify and investigate sources of dissatisfaction with a provider who is a participating provider in a private health benefit plan provided or sponsored by the sponsor, outline actions to follow up on the findings, and inform the provider of the findings;

(8) to give reasonable consideration, in selecting among health care providers for participation in a provider network serving a geographic area, to all providers who are legally authorized to provide health care services in the area; and

(9) to establish written policies and procedures to ensure that the confidentiality of protected health information (as defined in part 4) is protected in a manner consistent with part 4.

(c) OTHER REQUIREMENTS.—The quality standards for private plan sponsors—

(1) shall ensure that any physician incentive plan (as defined in subsection (d)) operated by a private plan sponsor is required to satisfy the requirements of clauses (i) and (ii) of section 1876(i)(8)(A) of the Social Security Act in the same manner as a physician incentive plan operated by an eligible organization (as defined in section 1876(b) of such Act) is required to satisfy the requirements of such clauses;

(2) shall require each private plan sponsor to provide each State in which the sponsor provides or sponsors a private health benefit plan with descriptive information sufficient to permit the State to determine whether the sponsor is in compliance with any requirement established with respect to such incentive plans under this section;

(3) shall require that if a physician incentive plan operated by a private plan sponsor places a physician or physician group at substantial financial risk (as determined by the Secretary) for services not provided by the physician or physician group, the sponsor shall make available, upon request by enrollees, health care providers, or potential enrollees or providers, descriptive information regarding any financial arrangements in the plan relating to controlling utilization or costs; and

(4) shall prohibit private plan sponsors from engaging in any formal or informal practice (including the practices described in subsection (e)) that in any way restricts a health care provider from communicating with a patient of the provider concerning the compensation of the provider, a term of any contract between the sponsor and the provider, or practices, protocols, or patterns of applying utilization review procedures of the sponsor, where such compensation, contract term, practice, protocol, or pattern may affect the patient's access to care.

(d) PHYSICIAN INCENTIVE PLAN DEFINED.—In this section, the term “physician incentive plan” means any compensation arrangement between a private plan sponsor and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled in a private health benefit plan provided or sponsored by the sponsor.

(e) SPECIFIC PRACTICES.—A formal or informal practice referred to in subsection (c)(4) includes—

(1) the establishment of contract provisions or protocols, the giving of oral instructions, and the imposition of sanctions; and

(2) practices that are intended to inhibit a health care provider from engaging in a communication described in subsection (c)(4).

(f) CIVIL MONEY PENALTIES.—Any private plan sponsor who the Secretary determines has violated a quality standard established by the Secretary under subsection (c)(4) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than \$10,000 for each such violation. The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply to a civil money penalty under this subsection in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

SEC. 9007. COMPLIANCE MONITORING BY APPROVED STATES.

(a) MONITORING.—An approved State shall monitor periodically, but not less than annually, compliance with requirements applicable to private plan sponsors and health care providers under this part by—

(A) private plan sponsors providing or sponsoring a private health benefit plan in the State; and

(B) health care providers licensed by the State.

(b) ENFORCEMENT.—

(1) PLAN SPONSORS.—If an approved State finds, after affording reasonable opportunities for improvement, that a private plan sponsor providing or sponsoring a private health benefit plan in the State, or a health care provider who is a participating provider of the plan, fails to engage in quality improvement activities or continues to furnish services of poor technical quality, the State shall enforce the requirements applicable to the sponsor under this part by—

(A) prohibiting the sponsor from providing coverage under the plan in the State under section 2202(a)(2) of the Social Security Act; or

(B) imposing a civil money penalty on the sponsor in accordance with section 2203 of such Act.

(2) HEALTH CARE PROVIDERS.—If an approved State finds, after affording reasonable opportunities for improvement, that a health care provider who is licensed by the State fails to engage in quality improvement activities or continues to furnish services of poor technical quality, the State shall enforce the requirements applicable to the provider under this part by directing one or more appropriate officials or agencies of the State to notify the appropriate Federal and State board or boards responsible for licensing, accrediting, and disciplining the provider.

SEC. 9008. GUIDELINE DEVELOPMENT AND RESEARCH ON HEALTH CARE QUALITY.

(a) DEVELOPMENT OF GUIDELINES.—

(1) PRACTICE GUIDELINES.—

(A) IN GENERAL.—The Secretary shall direct the Administrator for Health Care Policy and Research to develop and annually update practice guidelines of the type described in subparagraph (B). Guidelines under this paragraph shall be based on the best available data, including data from outcomes research, and clinical knowledge. Such guidelines shall be based on data that demonstrate the degree to which a process of care increases the probability of a desired patient outcome.

(B) GUIDELINE TYPE.—The type of practice guidelines referred to in subparagraph (A) are clinically relevant guidelines that may be used by health care providers to assist in determining how diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed clinically.

(2) GUIDELINES WITH RESPECT TO CERTAIN PROCEDURES.—

(A) IN GENERAL.—The Secretary shall direct the Administrator for Health Care Policy and Research to develop guidelines for certain medical procedures designated by the Administrator to be performed only in tertiary care centers which meet standards for frequency of procedure performance and intensity of support mechanisms that are consistent with the high probability of desired patient outcome.

(B) EFFECT OF FAILURE TO COMPLY WITH GUIDELINES.—

(i) EXCLUSION FROM COVERAGE.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)), as amended by sections 3103(b) and 3116(e)(1)(B), is amended—

(I) by striking “and” at the end of paragraph (17);

(II) by striking the period at the end of paragraph (18) and inserting “; or”; and

(III) by inserting after paragraph (18) the following:

“(19) furnished in violation of a guideline developed by the Administrator for Health Care Policy and Research under section 9008(a)(2)(A) of the Health Security Act.”.

(ii) PERMISSIVE EXCLUSION FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS.—Section 1128(b) of the Social Security Act (42 U.S.C. 1320a-7(b)) is amended by adding at the end the following:

“(15) FAILURE TO COMPLY WITH AHCPR GUIDELINES.—Any individual or entity furnishing items or services in violation of a guideline developed by the Administrator for Health Care Policy and Research under section 9008(a)(2)(A) of the Health Security Act.”.

(iii) STUDY AND REPORT.—The Administrator for Health Care Policy and Research shall conduct a study with respect to whether an item or service furnished in violation of a guideline developed under this paragraph should be excluded from the guaranteed national benefit package. Not later than the expiration of the 3-year period beginning on the date of the enactment of this Act, the Administrator shall sub-

mit a report to the Congress on the findings and recommendations of the Administrator in connection with the study.

(3) **PEDIATRIC PRACTICE GUIDELINES.**—Not later than 12 months after the date of the enactment of this Act, Secretary shall establish a procedure for the development of pediatric practice guidelines for the medical treatment of individuals under the age of 18. For purposes of developing such guidelines, the Secretary shall support research with respect to the outcomes of health care services and procedures provided to individuals under the age of 18.

(b) **EVALUATION, CERTIFICATION, AND DISSEMINATION OF GUIDELINES.**—

(1) **EVALUATION AND CERTIFICATION.**—Not later than 12 months after the date of the enactment of this Act, the Secretary shall establish a procedure by which individuals and entities may submit practice guidelines of the type described in subsection (a)(1)(B) to the Administrator for Health Care Policy and Research for evaluation and certification by the Administrator.

(3) **GUIDELINE CLEARINGHOUSE.**—The Secretary shall direct the Administrator for Health Care Policy and Research to establish and oversee a clearinghouse and dissemination program for practice guidelines that are certified under this subsection.

(c) **DISSEMINATION OF GUIDELINES.**—The Secretary shall disseminate any guideline developed, updated, or certified pursuant to this section to approved States, approved quality improvement organizations, health care providers, and other interested parties.

(d) **RESEARCH SUPPORT.**—The Secretary shall direct the Administrator for Health Care Policy and Research to support research, including research with respect to—

(1) outcomes of health care services and procedures;

(2) effective and efficient dissemination of information, standards, and guidelines;

(3) methods of measuring quality; and

(4) design and organization of quality of care components of automated health information systems.

(e) **INFORMATION COLLECTION AND DISSEMINATION.**—The Administrator for Health Care Policy and Research shall collect the results of research supported under subsection (d) and disseminate such results to approved States, approved quality improvement organizations, health care providers, and other interested parties.

(f) **NONDISCRIMINATION IN RESEARCH.**—A person who conducts biomedical or behavioral research involving human subjects, including clinical trials, may not directly or indirectly receive any funds under this Act (or any provision of law amended by this Act) if such person fails to comply with a guideline on the inclusion of women and minorities as subjects in clinical research established by the National Institutes of Health under section 492B of the Public Health Service Act.

(g) **AUTHORIZATIONS OF APPROPRIATIONS.**—

(1) **RESEARCH ON OUTCOMES.**—Section 1142(i) of the Social Security Act is amended—

(A) in paragraph (1)—

(i) in subparagraph (D), by striking “and”;

(ii) in subparagraph (E), by striking the period and inserting “; and”; and

(iii) by adding after subparagraph (E) the following:

“(F) \$6,000,000 for each of the fiscal years 1995 through 2000.”; and

(B) in paragraph (2), by striking “and 1994” and inserting “through 2000”.

(2) **HEALTH SERVICES RESEARCH.**—For the purpose of carrying out activities described in paragraphs (1) through (8) of section 902(a) of the Public Health Service Act by the Secretary of Health and Human Services, there are authorized to be appropriated \$6,000,000 for each of the fiscal years 1995 through 2000. Such authorization shall be in addition to any other authorization of appropriations that is available for such purpose.

SEC. 9009. QUALITY IMPROVEMENT ORGANIZATIONS.

(a) **IN GENERAL.**—

(1) **CONTRACTS.**—Subject to subsection (e), and using competitive contracting procedures, the Secretary shall enter into contracts with quality improvement organizations to perform the functions specified in subsection (c) for the geographic areas established under subsection (d)(1).

(2) **COMMENCEMENT.**—The Secretary may not enter into a contract under this section before the date that is 12 months after the date of the enactment of this Act or October 1, 1996, whichever occurs later.

(b) DEFINITION.—For purposes of this part, the term “quality improvement organization” means a private nonprofit entity that—

(1) has a governing body that is broadly representative of consumers of health care, purchasers of health care, health care providers, and representatives of academia;

(2) has a staff that includes individuals with expertise in the fields of quality improvement, epidemiology, patient outcome assessment, risk adjustment, clinical practice guidelines, health services data analysis, peer review, and provider and consumer education; and

(3) is able, in the judgment of the Secretary, to satisfy the requirements in paragraphs (1) and (2) of subsection (c).

(c) FUNCTIONS.—A quality improvement organization entering into a contract with the Secretary under this section—

(1) shall fulfill each requirement that is set forth in sections 9002 through 9008 and that is applicable to quality improvement organizations;

(2) shall assist in the development of innovative patient education programs;

(3) shall collaborate with, and provide technical assistance to, private plan sponsors and health care providers in ongoing efforts to improve the quality of care;

(4) shall conduct population-based monitoring of practice patterns and patient outcomes across private plan sponsors and health care providers;

(5) shall develop programs in lifetime learning;

(6) shall disseminate information about quality improvement programs; and

(7) shall maintain such records, make such reports (including expenditure reports), and cooperate with such audits, as the Secretary finds necessary to determine the compliance of the organization with the requirements of this part.

(d) CONTRACT SPECIFICATIONS.—

(1) ESTABLISHMENT OF GEOGRAPHIC AREAS.—The Secretary shall establish throughout the United States geographic areas with respect to which contracts under this section will be made. In establishing such areas, the Secretary shall take into account the following criteria:

(A) STATE AREAS.—Each State shall generally be designated as a geographic area for purposes of this paragraph.

(B) MULTI-STATE AREAS.—The Secretary may establish geographic areas comprised of multiple contiguous States rather than State areas only where the volume of activity or other relevant factors (as determined by the Secretary) warrant such an establishment.

(2) ORGANIZATIONS ENTITLED TO CONTRACT WITH SECRETARY.—

(A) IN GENERAL.—The Secretary shall enter into a contract with a quality improvement organization for each area established under paragraph (1) if a qualified organization is available in such area and such organization and the Secretary have negotiated a proposed contract which the Secretary determines will be carried out by such organization in a manner consistent with the efficient and effective administration of this part.

(B) LIMITATION ON AFFILIATIONS WITH PAYERS.—The Secretary may not enter into a contract under this section with any entity which is, or is affiliated with (through management, ownership, or common control), an entity (other than a self-insured employer) which directly or indirectly makes payments to any health care provider whose health care services are reviewed by such entity or would be reviewed by such entity if it entered into a contract with the Secretary under this section. For purposes of this subparagraph, an entity shall not be considered to be affiliated with another entity which makes payments (directly or indirectly) to any provider, by reason of management, ownership, or common control, if the management, ownership, or common control consists only of members of the governing board being affiliated (through management, ownership, or common control) with a private health benefit plan.

(C) LIMITATION ON AFFILIATIONS WITH PROVIDERS.—The Secretary may not enter into a contract under this section with any entity which is, or is affiliated with (through management, ownership, or common control), a health care provider, or association of such providers, within the area served by such entity or which would be served by such entity if it entered into a contract with the Secretary under this part. For purposes of this subparagraph, an entity shall not be considered to be affiliated with a health care provider or association of providers by reason of management, ownership, or common control if the management, ownership, or common control consists only of not more than 20 percent of the members of the governing

board of the entity being affiliated (through management, ownership, or common control) with one or more of such providers or associations.

(3) **TERMS OF CONTRACT.**—Each contract with an organization under this section shall provide that—

(A) the organization shall perform the functions set forth in subsection (c);

(B) the Secretary shall have the right to evaluate the quality and effectiveness of the organization in carrying out the functions specified in the contract;

(C) the contract shall be for an initial term of 3 years and shall be renewable for an additional term of 2 years thereafter without a competitive selection process based upon evidence of successful quality improvement activities;

(D) if the Secretary intends not to renew a contract, the Secretary shall notify the organization of the decision at least 90 days prior to the expiration of the contract term, and shall provide the organization an opportunity to present data, interpretations of data, and other information pertinent to its performance under the contract, which shall be reviewed in a timely manner by the Secretary;

(E) the organization may terminate the contract upon 90 days notice to the Secretary;

(F) the Secretary may terminate the contract prior to the expiration of the contract term upon 90 days notice to the organization if the Secretary determines that—

(i) the organization does not substantially meet the requirements of this section; or

(ii) the organization has failed substantially to carry out the contract or is carrying out the contract in a manner inconsistent with the efficient and effective administration of this part, but only after such organization has had an opportunity to submit data and have such data reviewed by the panel established under paragraph (4).

(4) **EVALUATION OF PERFORMANCE.**—In evaluating the performance of quality improvement organizations under contracts under this section, the Secretary shall place emphasis on the performance of such organizations in changing the behavior of health care providers with poor performance and educating health care providers concerning the process being used by the organization and the criteria being applied by the organization.

(5) **REVIEW PRIOR TO TERMINATION OF CONTRACT; MODIFICATION AND TERMINATION; REVIEWING PANEL.**—

(A) **IN GENERAL.**—Prior to making any termination under paragraph (3)(F), the Secretary shall provide the organization with an opportunity to provide data, interpretations of data, and other information pertinent to its performance under the contract. Such data and other information shall be reviewed in a timely manner by a panel appointed by the Secretary, and the panel shall submit a report of its findings to the Secretary in a timely manner. The Secretary shall make a copy of the report available to the organization.

(B) **SECRETARIAL AUTHORITY.**—The Secretary may accept or not accept the findings of the panel. After the panel has submitted a report with respect to an organization, the Secretary may, with the concurrence of the organization, amend the contract to modify the scope of the functions to be carried out by the organization, or in any other manner. The Secretary may terminate a contract under the authority of paragraph (3)(F) upon 90 days notice after the panel has submitted a report, or earlier if the organization so agrees.

(C) **COMPOSITION OF PANEL.**—A panel appointed by the Secretary under this paragraph shall consist of individuals appointed by the Secretary and paid while serving on the panel at a per diem rate determined by the Secretary. Individuals serving on a panel may be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and may be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of that title relating to classification and General Schedule pay rates.

(6) **CONTRACTING AUTHORITY OF SECRETARY.**—The contracting authority of the Secretary under this section may be carried out without regard to any provision of law relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent

with the purposes of this part. The Secretary may use different contracting methods with respect to different geographical areas.

(7) **TERMINATION NOT SUBJECT TO JUDICIAL REVIEW.**—Any determination by the Secretary to terminate or not to renew a contract under this section shall not be subject to judicial review.

(e) **ASSUMPTION OF RESPONSIBILITIES BY SECRETARY.**—If the Secretary determines that there is no qualified entity available for an area with which the Secretary can enter into a contract under this section, the Secretary shall take such steps as are necessary to perform in the area the duties applicable to approved quality improvement organizations under this part. Any information required under this part to be transmitted by any person to an approved quality improvement organization for an area shall be transmitted to the Secretary in the case where there is no qualified entity available for an area with which the Secretary can enter into a contract under this section.

(f) **LIMITATION OF LIABILITY.**—A quality improvement organization having a contract with the Secretary under this section, a person who is employed by, or who has a fiduciary relationship with, any such organization, and a person who furnishes professional services to such organization, may not be held, by reason of the performance of any duty, function, or activity required or authorized pursuant to this part or to a valid contract entered into under this section, to have violated any criminal law or to be civilly liable under any law of the United States or of any State (or political subdivision thereof), if the organization or person exercised good faith in the performance of such duty, function, or activity.

SEC. 9010. QUALITY MANAGEMENT GRANTS.

(a) **IN GENERAL.**—

(1) **GRANTS.**—The Secretary shall make a grant to each State that satisfies the requirements of this section.

(2) **COMMENCEMENT.**—The Secretary may not make a grant under this section before the date that is 12 months after the date of the enactment of this Act or October 1, 1996, whichever occurs later.

(b) **APPLICATIONS.**—

(1) **SUBMISSION.**—To apply for a grant under this section for any fiscal year, a State shall submit an application to the Secretary in accordance with the procedures established by the Secretary. The Secretary shall establish a deadline for the submission of applications under this paragraph for each fiscal year.

(2) **CRITERIA FOR APPROVAL.**—The Secretary may not approve an application submitted under paragraph (1) unless the application includes assurances satisfactory to the Secretary that—

(A) the State has a State regulatory program approved under section 2202(b) of the Social Security Act;

(B) the State is willing and able to fulfill each requirement that is set forth in sections 9002 through 9008 that is applicable to an approved State;

(C) the State will enforce the requirements set forth in sections 9002 through 9008 that are applicable to a private plan sponsor or a health care provider with respect to each private plan sponsor that provides or sponsors a private health benefit plan in the State and each health care provider licensed by the State, except in the case where another individual or entity is charged with such enforcement under this part;

(D) the State will maintain such records, make such reports (including expenditure reports), and cooperate with such audits, as the Secretary finds necessary to determine the compliance of the State (and persons regulated by the State) with the requirements of this part; and

(E) funds received under this section will be used for consumer protection and quality oversight activities.

(3) **PETITIONS FOR RECONSIDERATION AND REAPPLICATIONS.**—

(A) **IN GENERAL.**—With respect to an application submitted under paragraph (1) that is disapproved under this subsection, the applicant may submit to the Secretary—

(i) a petition for reconsideration of the application; and

(ii) an application that conforms to the requirements of this subsection.

(B) **DEADLINES.**—The Secretary shall establish a deadline for the submission of petitions for reconsideration and reapplications under this paragraph for each fiscal year. The Secretary shall approve or disapprove each such petition and reapplication before the termination of the 60-day period beginning on the date of such submission.

(c) **ABILITY TO SATISFY REQUIREMENTS THROUGH ARRANGEMENTS.**—A State may satisfy a requirement that is set forth in any of sections 9002 through 9008 directly or through arrangements with individuals or entities approved by the State that demonstrate to the satisfaction of the State that the individual or entity—

(1) has the ability to fulfill any duty delegated to the individual or entity by the State; and

(2) does not have a relationship with a private plan sponsor or a health care provider that would interfere with the ability of the individual or entity to fulfill any duty of a participating State under this part.

(d) **PERIODIC REVIEW.**—The Secretary shall periodically review the compliance by States that receive a grant under this section with the terms of the award of the grant.

(e) **FEDERAL ASSUMPTION OF STATE RESPONSIBILITIES.**—

(1) **IN GENERAL.**—In the case of a State that does not receive a grant under this section on or before January 1, 1998, or that substantially fails to satisfy a term of an award of such a grant, the Secretary shall take such steps as are necessary—

(A) to perform in the State the duties specified in sections 9002 through 9008 as duties of approved States;

(B) to enforce in the State the requirements set forth in sections 9002 through 9008 that are applicable to a private plan sponsor or a health care provider in the same manner as an approved State would be required to enforce such requirements under subsection (b)(2)(C).

(2) **DATA TRANSMISSION.**—Any information required under this part to be transmitted by any person to an approved State shall be transmitted to the Secretary in the case of a State described in paragraph (1).

SEC. 9011. AUTHORIZATION OF APPROPRIATIONS FOR CONTRACTS AND GRANTS.

There are authorized to be appropriated \$300,000,000 for each of the fiscal years 1997 through 2001 for contracts under section 9009 and for grants under section 9010.

SEC. 9012. HEALTH CARE QUALITY ADVISORY COMMISSION.

(a) **ESTABLISHMENT.**—The Secretary shall provide for the appointment of a Health Care Quality Advisory Commission, to be composed of individuals from the public and private sectors with expertise in the fields of health care quality and privacy of health information and representatives of consumers appointed by the Secretary (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service).

(b) **DUTIES.**—The Commission shall provide recommendations to the Secretary with respect to—

(1) the development and selection of the national measures of quality performance under section 9003, after consulting with appropriate interested parties, including the Administrator for Health Care Policy and Research, States, the National Association of Insurance Commissioners, private plan sponsors, health care providers, experts in quality measurement, nationally recognized accrediting bodies, other Federal advisory bodies, and consumers of health care services;

(2) the establishment of an appropriate sequence for the interim sets of national measures of quality performance under section 9003(a)(4);

(3) the guidelines required to be issued by the Secretary under section 9041(c)(2); and

(4) the establishment of the uniform clinical data sets under section 9104.

(c) **MEMBERSHIP.**—The Commission shall be composed of 11 members. Members of the Commission shall first be appointed not later than 6 months after the date of the enactment of this Act for a term of 3 years, except that the Secretary may provide initially for such shorter terms as will ensure that (on a continuing basis) the terms of not more than 4 member expire in any one year.

(d) **DURATION.**—Notwithstanding section 14(a) of the Federal Advisory Committee Act, the Commission shall continue in existence until otherwise provided by law.

(e) **REPORT.**—The Commission shall submit to the Congress an annual report not later than May 1 of each year concerning the activities of the Commission under this part during the preceding year.

SEC. 9013. DEFINITIONS.

Unless otherwise provided in this subtitle, for purposes of this subtitle:

(1) **APPROVED STATE.**—The term “approved State” means a State that receives a grant under section 9010.

(2) **APPROVED QUALITY IMPROVEMENT ORGANIZATION.**—The term “approved quality improvement organization” means a quality improvement organization

that has a contract with the Secretary under section 9009. When used with respect to a geographic area, such term means a quality improvement organization that is responsible under such a contract for carrying out the responsibilities of approved quality improvement organizations under this part in a geographic area established under section 9009(d)(1).

(3) **HEALTH CARE PROVIDER.**—The term “health care provider” means an institution providing health care and a health care professional.

(4) **HEALTH INSTITUTION.**—The term “health institution” means a hospital, a skilled nursing facility, and an ambulatory surgery center.

(5) **PARTICIPATING PROVIDER.**—The term “participating provider”, when used with respect to a private health benefit plan, means a health care provider who is member of a provider network of the plan.

(6) **PRIVATE HEALTH BENEFIT PLAN.**—The term “private health benefit plan” means a health benefit plan (as defined in section 2204(3) of the Social Security Act), but does not include any Federal or State entity or program that provides directly for the provision of health services or provides for payments for such services.

(7) **PRIVATE PLAN SPONSOR.**—The term “private plan sponsor” has the meaning given the term “sponsor” in section 2204(12) of the Social Security Act in relation to a private health benefit plan.

(8) **PROVIDER NETWORK.**—The term “provider network” means, with respect to a private health benefit plan, health care providers who have entered into an agreement with the plan under which such providers are obligated to provide items and services covered under the plan to individuals enrolled in the plan, or have an agreement to provide services on a fee-for-service basis.

SEC. 9014. EFFECTIVE DATES.

(a) **IN GENERAL.**—Except as provided in subsection (b), the provisions of this part shall take effect on the date that is 24 months after the date of the enactment of this Act.

(b) **PROVISIONS EFFECTIVE IMMEDIATELY.**—

(1) **SECRETARIAL RESPONSIBILITIES.**—The following provisions imposing a duty on the Secretary shall take effect on the date of the enactment of this Act:

(A) Section 9001.

(B) Section 9002(c).

(C) Subsections (a), (b), (c), and (h) of section 9003.

(D) Section 9004(a).

(E) Subsections (b), (c), (d), (e), and (i) of section 9005.

(F) Sections 9006, 9008, 9009, 9010, and 9012.

(2) **AUTHORIZATION OF APPROPRIATIONS.**—Section 9011 shall take effect on the date of the enactment of this Act.

PART 2—GRIEVANCE AND APPEALS PROCESS

SEC. 9021. HEALTH PLAN CLAIMS PROCEDURE.

(a) **DEFINITIONS.**—For purposes of this part—

(1) **CLAIM.**—The term “claim” means a request for payment or provision of benefits under a private health benefit plan (including a request for restoration of any item or service which has been provided in the course of treatment and is alleged to have been wrongfully terminated or reduced by the private plan sponsor providing or sponsoring the plan) or a request for preauthorization of items or services which is submitted to a private plan sponsor prior to receipt of the items or services.

(2) **INDIVIDUAL CLAIMANT.**—The term “individual claimant” with respect to a claim means any individual who submits the claim to a private plan sponsor in connection with the individual’s enrollment under a private health benefit plan provided or sponsored by the sponsor, or on whose behalf the claim is submitted to the plan by a provider.

(3) **PROVIDER CLAIMANT.**—The term “provider claimant” with respect to a claim means any provider who submits a claim to a private plan sponsor with respect to items or services provided to an individual enrolled under a private health benefit plan provided or sponsored by the sponsor.

(b) **GENERAL RULES GOVERNING TREATMENT OF CLAIMS.**—

(1) **ADEQUATE NOTICE OF DISPOSITION OF CLAIM.**—In any case in which a claim is submitted in complete form to a private plan sponsor, the sponsor shall provide to the individual claimant and any provider claimant with respect to the claim a written notice of the sponsor’s approval or denial of the claim within

30 days after the date of the submission of the claim. The notice to the individual claimant shall be written in language calculated to be understood by the typical individual enrolled under the plan and in a form which takes into account accessibility to the information by individuals whose primary language is not English. In the case of a denial of the claim, the notice shall set forth the specific reasons for the denial. The notice of a denial shall include notice of the right to appeal the denial under paragraph (2). Failure by any sponsor to comply with the requirements of this paragraph with respect to any claim submitted to the sponsor be treated as approval by the sponsor of the claim.

(2) DUTY TO REVIEW DENIALS UPON TIMELY REQUEST.—The sponsor shall review its denial of a claim if an individual claimant or provider claimant with respect to the claim submits to the sponsor a written request for reconsideration after receipt of written notice from the sponsor of the denial. The sponsor shall allow any such claimant not less than 60 days, after receipt of written notice from the sponsor, to submit the request for reconsideration.

(3) TIME LIMIT FOR REVIEW.—The sponsor shall complete any review required under paragraph (2), and shall provide the individual claimant and any provider claimant with respect to the claim written notice of the sponsor's decision on the claim after reconsideration pursuant to the review, within 30 days after the date of the receipt of the request for reconsideration.

(4) DE NOVO REVIEWS.—Any review required under paragraph (2)—

(A) shall be de novo;

(B) shall be conducted by an individual who did not make the initial decision denying the claim and who is authorized to approve the claim; and

(C) shall include review by a qualified physician if the resolution of any issues involved requires medical expertise.

(c) TREATMENT OF URGENT REQUESTS TO PLANS FOR PREAUTHORIZATION.—

(1) IN GENERAL.—This subsection applies in the case of any claim submitted by an individual claimant or a provider claimant consisting of a request for preauthorization of items or services (other than emergency services which under title XXII of the Social Security Act may not be subject to preauthorization) which is accompanied by an attestation that—

(A) failure to immediately provide the items or services could reasonably be expected to result in—

(i) placing the health of the individual claimant (or, with respect to an individual claimant who is a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(ii) serious impairment to bodily functions; or

(iii) serious dysfunction of any bodily organ or part; or

(B) immediate provision of the items or services is necessary because the individual claimant has made or is at serious risk of making an attempt to harm such individual claimant or another individual.

(2) SHORTENED TIME LIMIT FOR CONSIDERATION OF REQUESTS FOR PREAUTHORIZATION.—Notwithstanding subsection (b)(1), a private plan sponsor shall approve or deny any claim described in paragraph (1) within 24 hours after submission of the claim to the sponsor. Failure by the sponsor to comply with the requirements of this paragraph with respect to the claim shall be treated as approval by the sponsor of the claim.

(3) EXPEDITED EXHAUSTION OF PLAN REMEDIES.—Any claim described in paragraph (1) which is denied by the sponsor shall be treated as a claim with respect to which all remedies under the plan provided pursuant to this section are exhausted, irrespective of any review provided under subsection (b)(2).

(4) DENIAL OF PREVIOUSLY AUTHORIZED CLAIMS NOT PERMITTED.—In any case in which a sponsor approves a claim described in paragraph (1)—

(A) the sponsor may not subsequently deny payment or provision of benefits pursuant to the claim, unless the sponsor makes a showing of an intentional misrepresentation of a material fact by the individual claimant; and

(B) in the case of a violation of subparagraph (A) in connection with the claim, all remedies under the plan provided pursuant to this section with respect to the claim shall be treated as exhausted.

(d) TIME LIMIT FOR DETERMINATION OF INCOMPLETENESS OF CLAIM.—For purposes of this section—

(1) any claim submitted by an individual claimant and accepted by a provider serving under contract with a private plan sponsor and any claim described in subsection (b)(1) shall be treated with respect to the individual claimant as submitted in complete form;

(2) any other claim for benefits under the plan shall be treated as filed in complete form as of 30 days after the date of the submission of the claim, unless

the plan provides to the individual claimant and any provider claimant, within such period, a written notice of any required matter remaining to be filed in order to complete the claim.

Any filing by the individual claimant or the provider claimant of additional matter requested by the plan pursuant to paragraph (2) shall be treated for purposes of this section as an initial filing of the claim.

(e) **ADDITIONAL NOTICE AND DISCLOSURE REQUIREMENTS FOR HEALTH PLANS.**—In the case of a denial of a claim for benefits under a private health benefit plan, the sponsor providing or sponsoring the plan shall include, together with the specific reasons provided to the individual claimant and any provider claimant under subsection (b)(1)—

(1) if the denial or determination is based in whole or in part on a determination that the claim is for an item or service which is not covered by the guaranteed national benefit package, exceeds the maximum payment rate (if any) applicable to the class of service under title VI, or exceeds payment rates under any applicable fee schedule the factual basis for the determination;

(2) if the denial or determination is based in whole or in part on exclusion of coverage with respect to services because the services are determined to comprise an experimental treatment or investigatory procedure, the medical basis for the determination and a description of the process used in making the determination; and

(3) if the denial or determination is based in whole or in part on a determination that the treatment is not medically necessary or appropriate or is inconsistent with the sponsor's practice guidelines, the medical basis for the determination, the guidelines used in making the determination, and a description of the process used in making the determination.

(f) **WAIVER OF RIGHTS PROHIBITED.**—A private plan sponsor may not require any party to waive any right under a private health benefit plan provided or sponsored by the sponsor or this Act as a condition for approval of any claim under the plan, except to the extent otherwise specified in a formal settlement agreement.

SEC. 9022. DETERMINATIONS BY PRIVATE PLAN SPONSORS PROVIDING ITEMS AND SERVICES TO ENROLLEES.

(a) **APPLICABILITY.**—This section applies in the case of a private plan sponsor to the extent it provides benefits in the form of items and services to enrollees. This section does not apply in the case of a private plan sponsor to the extent it provides benefits in the form of reimbursement to individual claimants or provider claimants for items and services.

(b) **DENIAL OF ITEMS OR SERVICES CLARIFIED.**—For purposes of this section, a denial of items or services by a private plan sponsor includes the termination or reduction by the sponsor of any item or service which has been provided in the course of treatment.

(c) **GENERAL RULES GOVERNING DENIALS OF ITEMS OR SERVICES.**—

(1) **ADEQUATE NOTICE.**—A private plan sponsor shall provide any individual who is denied items or services by the sponsor an adequate written notice of the denial. The notice shall be provided within 30 days after the denial. Such notice shall be written in language calculated to be understood by the typical individual enrolled under a private health benefit plan provided or sponsored by the sponsor and in a form which takes into account accessibility to the information by individuals whose primary language is not English. The notice shall set forth the specific reasons for the denial and shall include notice of the right to appeal the denial under paragraph (2). Failure by any sponsor to comply with the requirements of this paragraph with respect to a denial of an item or service by the sponsor with respect to a private health benefit plan shall result in the claimant being permitted to receive such items or services from a health care provider who is not a member of a provider network of the plan and the sponsor being liable to pay such provider for such items or services.

(2) **PLAN'S DUTY TO REVIEW DENIALS UPON TIMELY REQUEST.**—The sponsor shall review its denial of an item or service if the individual aggrieved by the denial submits to the sponsor a written request for reconsideration after receipt of written notice from the sponsor under paragraph (1). The sponsor shall allow any such individual not less than 60 days, after receipt of written notice from the sponsor, to submit the request for reconsideration.

(3) **CONDITIONS ON REVIEW; WAIVER OF RIGHTS.**—The provisions of paragraphs (3) and (4) of subsection (b), and subsections (e) and (f), of section 9021 shall apply to a denial by a sponsor of an item or service under this section in the same manner as such provisions apply to a denial of a claim under section 9021.

SEC. 9023. BOARDS OF APPEAL FOR MANAGED CARE PLANS AND POINT-OF-SERVICE PLANS.

(a) **IN GENERAL.**—Each carrier offering a managed care plan or a point-of-service plan shall provide for a board of appeals to conduct reviews of certain denials in accordance with this section.

(b) **COMPOSITION.**—A board of appeals for a plan shall—

(1) consist of—

(A) representatives of the carrier offering the plan, including physicians who are members of the plan's provider network, plan administrators, and individuals enrolled in the plan; and

(B) individual consumers who are not enrolled in the plan; and

(2) include physicians who have expertise in the field of medicine directly related to the item or service involved in an appeal.

(c) **DUTIES.**—A board of appeals shall—

(1) conduct reviews of denials under and in accordance with sections 9021 and 9022 in the cases of—

(A) the refusal of a carrier offering a managed care plan to provide coverage of covered items and services through a provider who is a member of the plan's provider network,

(B) the denial of payment by such a carrier for covered items and services furnished pursuant to section 2119(d), or

(C) the refusal of a carrier offering a point-of-service plan to provide coverage of covered items and services through a provider who is a member of the plan's provider network; and

(2) make determinations regarding the medical necessity or appropriateness of covered items or services that are the subject of such reviews.

(d) **DEADLINE FOR DETERMINATION.**—A board of appeals shall make a final determination with respect to a review under this section within the 30-day period specified or provided under section 9021(b)(3) or 9022(c)(3), whichever is applicable.

SEC. 9024. REVIEW IN STATE COMPLAINT REVIEW OFFICES OF GRIEVANCES BASED ON ACTS OR PRACTICES BY PRIVATE PLAN SPONSORS.

(a) **IN GENERAL.**—In accordance with rules which shall be prescribed by the Secretary not later than 12 months after the date of the enactment of this Act, each State shall establish and maintain a complaint review office for the State.

(b) **FILINGS OF COMPLAINTS BY AGGRIEVED PERSONS.**—In the case of any person who is aggrieved by any act or practice engaged in by a private plan sponsor which consists of or results in denial of payment or provision of benefits under a private health benefit plan (including a long-term care insurance policy) provided or sponsored by the sponsor or delay in the payment or provision of benefits (under sections 9021 or 9022), if the denial or delay consists of a failure to comply with the terms of the plan (including the provision of benefits in full when due in accordance with the terms of the plan), or with the applicable requirements of this Act, such person may file a complaint with a complaint review office established by—

(1) a State in which the person resides; or

(2) the State which is the principal place of business of the person.

SEC. 9025. EXHAUSTION OF REMEDIES.

Any complaint including a claim to which section 9021 applies, and any complaint including an allegation of denial of items or services to which section 9022 applies, may not be filed in any court or complaint review office until the complainant has exhausted all remedies provided by the sponsor under the plan with respect to the claim or denial in accordance with such sections. In such a case, the court or review office shall determine the matter *de novo*.

SEC. 9026. EFFECTIVE DATE.

This part shall take effect on the date that is 24 months after the date of the enactment of this Act, except that the requirement on the Secretary to promulgate rules under section 9024(a) shall take effect on the date of the enactment of this Act.

PART 3—ANTI-DISCRIMINATION**SEC. 9031. REQUIREMENTS RELATING TO STATES.**

(a) **IN GENERAL.**—A State, or a person acting under the authority of a State, may not discriminate, or engage (directly or through contractual arrangements) in any activity that has the effect of discriminating, in carrying out any responsibility or in exercising any authority under this Act, against an individual or entity on the

basis of race, age, sex, sexual orientation, language, religion, national origin, income, disability, perceived health status, or anticipated need for health services.

(b) **BOUNDARIES.**—In establishing boundaries for health alliance areas (or other similar boundaries), a State may not discriminate, engage (directly or through contractual arrangements) in any activity that has the effect of discriminating, or otherwise take into account, race, age, sex, sexual orientation, language, religion, national origin, income, disability, perceived health status, or anticipated need for health services.

(c) **REMEDY.**—A person who is aggrieved by a violation of subsection (a) or (b) may, in a civil action, obtain appropriate relief, including compensatory and punitive damages and equitable relief, against any appropriate party, including a State.

(d) **ATTORNEY'S FEES.**—In an action under subsection (c), the court, in its discretion, may allow the prevailing party a reasonable attorney's fee (including expert fees) as part of the costs.

SEC. 9032. REQUIREMENTS RELATING TO HEALTH ALLIANCES.

(a) **ALLIANCE ACTIVITIES RELATING TO HEALTH PLANS.**—A health alliance may not discriminate, or engage (directly or through contractual arrangements) in any activity that has the effect of discriminating, against a private plan sponsor providing or sponsoring a private health benefit plan on the basis of—

(1) mix of health professionals associated with the plan;

(2) organizational arrangement of the plan (except as specifically provided in this Act;

(3) personal characteristics of an individual enrolled in the plan or considering enrolling in the plan that are unrelated to whether the individual is eligible to enroll in the plan, such as race, age, sex, sexual orientation, language, religion, national origin, income, disability, perceived health status, or anticipated need for health services; or

(4) personal characteristics of a health care provider who is a participating provider of the plan, such as race, age, sex, sexual orientation, language, religion, national origin, income, disability, perceived health status, or anticipated need for health services.

(b) **OTHER ALLIANCE ACTIVITIES.**—A health alliance may not discriminate, or engage (directly or through contractual arrangements) in any other activity that has the effect of discriminating, against an individual or entity on the basis of race, age, sex, sexual orientation, language, religion, national origin, income, disability, perceived health status, or anticipated need for health services.

(c) **REMEDY.**—A person who is aggrieved by a violation of subsection (a) or (b) may, in a civil action, obtain appropriate relief, including compensatory and punitive damages and equitable relief, against any appropriate party.

(d) **ATTORNEY'S FEES.**—In an action under subsection (c), the court, in its discretion, may allow the prevailing party a reasonable attorney's fee (including expert fees) as part of the costs.

(e) **EXHAUSTION OF REMEDIES.**—In an action under subsection (c), the court shall exercise jurisdiction without regard to whether the aggrieved person has exhausted any administrative or other remedies that may be provided by law.

SEC. 9033. REQUIREMENTS RELATING TO PLAN SPONSORS.

(a) **UNDERWRITING.**—A private plan sponsor providing or sponsoring a private health benefit plan may not engage in any practice that has the effect of attracting or limiting enrollees on the basis of personal characteristics that are unrelated to the eligibility of an individual to enroll in the plan, such as race, age, sex, sexual orientation, language, religion, national origin, income, disability, perceived health status, or anticipated need for health services.

(b) **SELECTION OF PARTICIPATING PROVIDERS.**—In selecting among health care providers for membership in a provider network, or in establishing the terms and conditions of such membership, a private plan sponsor described in subsection (a) may not discriminate, or engage (directly or through contractual arrangements) in any activity that has the effect of discriminating, against a health care provider—

(1) based on personal characteristics of the provider, such as race, age, sex, sexual orientation, language, religion, national origin, income, disability, perceived health status, or anticipated need for health services; or

(2) based on personal characteristics of a patient of the provider, such as race, age, sex, sexual orientation, language, religion, national origin, income, disability, perceived health status, or anticipated need for health services.

(c) **OTHER SPONSOR ACTIVITIES.**—A private plan sponsor described in subsection (a) may not discriminate, or engage (directly or through contractual arrangements) in any other activity that has the effect of discriminating, against an individual or entity on the basis of race, age, sex, sexual orientation, language, religion, national

origin, income, disability, perceived health status, or anticipated need for health services.

(d) **BUSINESS NECESSITY.**—Except in the case of intentional discrimination, a private plan sponsor may not be considered to be in violation of this section, or of any regulations issued under this section, if the sponsor demonstrates, in a civil action under subsection (e), that each action of the sponsor that is otherwise prohibited under this section is required by a compelling business necessity and cannot be accomplished by less discriminatory means.

(e) **REMEDY.**—A person who is aggrieved by a violation of this section may, in a civil action, obtain appropriate relief, including compensatory and punitive damages and equitable relief, against any appropriate party.

(f) **ATTORNEY'S FEES.**—In an action under subsection (e), the court, in its discretion, may allow the prevailing party a reasonable attorney's fee (including expert fees) as part of the costs.

(g) **EXHAUSTION OF REMEDIES.**—In an action under subsection (e), the court shall exercise jurisdiction without regard to whether the aggrieved individual has exhausted any administrative or other remedies that may be available to the individual under part 2 or that are otherwise provided by law.

SEC. 9034. NONDISCRIMINATION IN FEDERALLY ASSISTED PROGRAMS.

(a) **IN GENERAL.**—No person in the United States shall, on the basis of race, age, sex, sexual orientation, language, religion, national origin, income, disability, perceived health status, or anticipated need for health services, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity receiving Federal financial assistance.

(b) **PRIVATE REMEDY.**—

(1) **IN GENERAL.**—A person who is aggrieved by a violation of this section may, in a civil action, obtain appropriate relief, including compensatory and punitive damages and equitable relief, against any appropriate party.

(2) **ATTORNEY'S FEES.**—In an action under this subsection, the court, in its discretion, may allow the prevailing party a reasonable attorney's fee (including expert fees) as part of the costs.

(c) **ADMINISTRATIVE POWERS.**—

(1) **IN GENERAL.**—Each Federal department and agency which is empowered to extend Federal financial assistance to any health program or activity shall effectuate the provisions of this section with respect to such program or activity in accordance with the remedies, procedures and rights set forth in title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.).

(2) **CONSTRUCTION.**—Paragraph (1) shall not be construed to supercede, limit, or otherwise affect any provision of the Social Security Act or any duty or authority of the Secretary under such Act.

(d) **DEFINITIONS.**—For purposes of this section, the terms "program or activity", and "program" have the meaning given such terms in section 606 of the Civil Rights Act of 1964 (42 U.S.C. 2000d-4a).

SEC. 9035. COLLECTION AND REPORTING OF DATA BY SECRETARY.

(a) **IN GENERAL.**—The Secretary shall promulgate regulations that provide for the routine collection, analysis, and reporting, by race, national origin, sex, language, income, age, and residence, of data collected from States, health alliances, private plan sponsors, and any other person or entity determined appropriate by the Secretary that the Secretary determines are necessary or appropriate to determine whether such individuals and entities are complying with this part. The Secretary shall compile, analyze, and make public the data collected under this section.

(b) **NO UNDUE BURDEN.**—The regulations under subsection (a) shall include specifications ensuring that any data required to be collected under this section may be collected using the least burdensome method consistent with the efficient and effective administration of this part.

SEC. 9036. REGULATIONS.

Not later than 1 year after the date of the enactment of this Act, the Secretary shall issue regulations to carry out this part.

PART 4—PRIVACY STANDARDS FOR PROTECTED HEALTH INFORMATION

SEC. 9041. GENERAL LIMITATIONS ON USE AND DISCLOSURE.

(a) **USE.**—A health information trustee may use protected health information only for a purpose that is compatible with and related to the purpose for which the information—

- (1) was collected; or
- (2) was received by the trustee.

(b) **DISCLOSURE.**—A health information trustee may disclose protected health information only for a purpose that is authorized under this part.

(c) **SCOPE OF USES AND DISCLOSURES.**—

(1) **IN GENERAL.**—A use or disclosure of protected health information by a health information trustee shall be limited, when practicable, to the minimum amount of information necessary to accomplish the purpose for which the information is used or disclosed.

(2) **GUIDELINES.**—Not later than July 1, 1996, the Secretary, after notice and opportunity for public comment, shall issue guidelines to implement paragraph

(1), which shall take into account—

(A) the recommendations of the Health Care Quality Advisory Commission under section 9012; and

(B) the technical capabilities of the record systems used to maintain protected health information and the costs of limiting use and disclosure.

(d) **AGREEMENT TO LIMIT USE OR DISCLOSURE.**—A health information trustee who receives protected health information from any person pursuant to a written agreement to restrict use or disclosure of the information to a greater extent than would otherwise be required under this part shall comply with the terms of the agreement, except where use or disclosure of the information in violation of the agreement is required by law. A trustee who fails to comply with the preceding sentence shall be subject to section 9055 (relating to civil actions) with respect to such failure.

(e) **NO GENERAL REQUIREMENT TO DISCLOSE.**—Except as provided in section 9051, nothing in this Act shall be construed to require a health information trustee to disclose protected health information not otherwise required to be disclosed by law.

SEC. 9042. TREATMENT, PAYMENT, AND OVERSIGHT.

A health information trustee may disclose protected health information if the disclosure is—

(1) for the purpose of providing health care to an individual and the individual who is the subject of the information has not previously objected to the disclosure in writing;

(2) for the purpose of providing for the payment for health care furnished to an individual; or

(3) for use by a health oversight agency for a purpose authorized by law.

SEC. 9043. PUBLIC HEALTH.

(a) **IN GENERAL.**—A health information trustee may disclose protected health information for use in legally authorized—

- (1) disease or injury reporting;
- (2) public health surveillance; or
- (3) public health investigation.

(b) **USE IN ACTION AGAINST INDIVIDUAL.**—Protected health information about an individual that is disclosed under this section may not be used in, or disclosed to any person for use in, any administrative, civil, or criminal action or investigation directed against the individual, except where the use or disclosure is authorized by law for protection of the public health.

SEC. 9044. EMERGENCY CIRCUMSTANCES.

A health information trustee may disclose protected health information to alleviate emergency circumstances affecting the health or safety of an individual.

SEC. 9045. JUDICIAL, ADMINISTRATIVE, AND OTHER LEGAL PURPOSES.

(a) **IN GENERAL.**—A health information trustee may disclose protected health information—

(1) pursuant to the Federal Rules of Civil Procedure, the Federal Rules of Criminal Procedure, or comparable rules of other courts or administrative agencies in connection with litigation or proceedings to which the individual who is the subject of the information is a party and in which the individual has placed the individual's physical or mental condition in issue;

(2) pursuant to a law requiring the reporting of specific medical information to law enforcement authorities;

(3) if the disclosure is of information described in paragraph (2) and the trustee is operated by a Federal agency;

(4) if directed by a court in connection with a court-ordered examination of an individual; or

(5) to assist in the identification of a dead individual.

(b) **WRITTEN STATEMENT.**—A person seeking protected health information about an individual maintained by health information trustee under—

(1) subsection (a)(1) shall provide the trustee with a written statement that the individual is a party to the litigation or proceedings for which the information is sought; or

(2) subsection (a)(5) shall provide the trustee with a written statement that the information is sought to assist in the identification of a dead individual.

(c) **USE AND DISCLOSURE.**—A person to whom protected health information is disclosed under this section may use and disclose the information only under a condition described in subsection (a).

SEC. 9046. LAW ENFORCEMENT.

(a) **IN GENERAL.**—A health information trustee may disclose protected health information to a law enforcement agency (other than a health oversight agency) if the information is for use in an investigation or prosecution, as authorized by law.

(b) **RESTRICTIONS ON DISCLOSURE AND USE.**—Protected health information about an individual that is disclosed by a health information trustee to a law enforcement agency under this section—

(1) may not be disclosed for, or used in, any administrative, civil, or criminal action or investigation against the individual, except in an action or investigation arising out of and directly related to the action or investigation for which the information was obtained; and

(2) may not be otherwise used or disclosed by the agency, unless the use or disclosure is necessary to fulfill the purpose for which the information was obtained and is not otherwise prohibited by law.

SEC. 9047. SUBPOENAS, WARRANTS, AND SEARCH WARRANTS.

(a) **IN GENERAL.**—A health information trustee may disclose protected health information if the disclosure is pursuant to any of the following:

(1) A subpoena issued under the authority of a grand jury.

(2) An administrative subpoena or warrant or a judicial subpoena or search warrant.

(b) **RESTRICTIONS ON USE AND DISCLOSURE.**—Protected health information about an individual that is disclosed by a health information trustee under—

(1) subsection (a) may not be disclosed for, or used in, any administrative, civil, or criminal action or investigation against the individual, except in an action or investigation arising out of and directly related to the inquiry for which the information was obtained; and

(2) subsection (a)(2) may not be otherwise used or disclosed by the recipient unless the use or disclosure is necessary to fulfill the purpose for which the information was obtained.

(c) **COPY AS PART OF PROTECTED INFORMATION.**—A health information trustee who discloses protected health information under this section shall maintain a copy of the applicable subpoena, warrant, or search warrant as part of the information.

(d) **CONSTRUCTION.**—Nothing in this section shall be construed as authority for a health information trustee to refuse to comply with an administrative subpoena or warrant or a judicial subpoena or search warrant that meets the requirements of this Act.

SEC. 9048. HEALTH RESEARCH AND QUALITY ASSESSMENT.

(a) **HEALTH RESEARCH.**—A health information trustee may disclose protected health information to a health researcher if the disclosure is for use in a health research project that has been determined by an institutional review board to be—

(1) of sufficient importance so as to outweigh the intrusion into the privacy of the individual who is the subject of the information that would result from the disclosure; and

(2) reasonably impracticable to conduct without such information.

(b) **OBLIGATIONS OF RECIPIENT.**—A person who receives protected health information pursuant to subsection (a) shall remove or destroy, at the earliest opportunity consistent with the purposes of the project, information that would enable 1 or more individuals to be identified, unless an institutional review board has determined that there is a health or research justification for retention of such identifiers and

there is an adequate plan to protect the identifiers from use and disclosure that is inconsistent with this Act.

(c) **QUALITY ASSESSMENT.**—A health information trustee may disclose protected health information to a Federal or State agency, or an individual or entity that has an arrangement with such an agency, performing a duty under the National Quality Management Program under part 1.

(d) **LICENSING, ACCREDITATION, AND CERTIFICATION.**—A health information trustee may disclose protected health information for use in licensing, accrediting, or certifying health care providers.

SEC. 9049. NEXT OF KIN AND DIRECTORY INFORMATION.

(a) **NEXT OF KIN.**—A health information trustee may disclose protected health information to the next of kin or legal representative (as defined under State law) of the individual who is the subject of the information, or to a person with whom the individual has a personal relationship, if—

- (1) the individual has not previously objected to the disclosure;
- (2) the disclosure is consistent with accepted medical practice; and
- (3) the information disclosed relates to the ongoing provision of health care to the individual.

(b) **DIRECTORY INFORMATION.**—A health information trustee may disclose protected health information about an individual to any person, if—

- (1) the information does not reveal specific information about the physical or mental condition of the individual or health care provided to the individual;
- (2) the individual who is the subject of the information has not objected in writing to the disclosure;
- (3) the disclosure is consistent with accepted medical practice; and
- (4) the information consists only of 1 or more of the following items:

(A) The name of the individual.

(B) If the individual is receiving health care from a health care provider on a premises controlled by the provider, the location of the individual on such premises.

(C) If the individual is receiving health care from a health care provider on a premises controlled by the provider, the general health status of the individual, described in terms of critical, poor, fair, stable, satisfactory, or terms denoting similar conditions.

(c) **RECIPIENTS.**—A person to whom protected health information is disclosed under this section shall not, by reason of such disclosure, be subject to any requirement under this Act.

SEC. 9050. AUTHORIZATIONS FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION.

(a) **WRITTEN AUTHORIZATIONS.**—A health information trustee may disclose protected health information pursuant to an authorization executed by the individual who is the subject of the information, if each of the following requirements is met:

(1) **WRITING.**—The authorization is in writing, signed by the individual, and dated on the date of such signature.

(2) **SEPARATE FORM.**—The authorization is not on a form used to authorize or facilitate the provision of, or payment for, health care.

(3) **TRUSTEE DESCRIBED.**—The trustee is specifically named or generically described in the authorization as authorized to disclose such information.

(4) **RECIPIENT DESCRIBED.**—The person to whom the information is to be disclosed is specifically named or generically described in the authorization as a person to whom such information may be disclosed.

(5) **INFORMATION DESCRIBED.**—The information to be disclosed is described in the authorization.

(6) **AUTHORIZATION TIMELY RECEIVED.**—The authorization is received by the trustee during a period established by the Secretary.

(7) **DISCLOSURE TIMELY MADE.**—The disclosure occurs during a period established by the Secretary.

(b) **AUTHORIZATIONS REQUESTED IN CONNECTION WITH PROVISION OF HEALTH CARE.**—

(1) **IN GENERAL.**—A health information trustee may not request that an individual provide to any person an authorization described in subsection (a) on a day on which—

(A) the trustee provides health care to the individual; or

(B) in the case of a trustee that is a health facility, the individual is admitted into the facility as a resident or inpatient in order to receive health care.

(2) **EXCEPTION.**—Paragraph (1) does not apply if a health information trustee requests that an individual provide an authorization described in subsection (a)

for the purpose of assisting the individual in obtaining counseling or social services from a person other than the trustee.

(c) **REVOCATION OR AMENDMENT OF AUTHORIZATION.**—

(1) **IN GENERAL.**—An individual in writing may revoke or amend an authorization described in subsection (a), in whole or in part, at any time, except when—

(A) disclosure of protected health information has been authorized to permit validation of expenditures for health care, or based on health condition, by a government authority; or

(B) action has been taken in reliance on the authorization.

(2) **NOTICE OF REVOCATION.**—A health information trustee who discloses protected health information pursuant to an authorization that has been revoked shall not be subject to any liability or penalty under this Act if—

(A) the reliance was in good faith;

(B) the trustee had no notice of the revocation; and

(C) the disclosure was otherwise in accordance with the requirements of this Act.

(d) **EFFECT OF AUTHORIZATION ON PRIVILEGES.**—The execution by an individual of an authorization that meets the requirements of this section for the purpose of receiving health care or providing for the payment for health care shall not be construed as affecting any privilege that the individual may have under common or statutory law in a court of a State or the United States.

(e) **ADDITIONAL REQUIREMENTS OF TRUSTEE.**—A health information trustee may impose requirements for an authorization that are in addition to the requirements in this section.

(f) **COPY.**—A health information trustee who discloses protected health information pursuant to an authorization under this section shall maintain a copy of the authorization as part of the information.

(g) **CONSTRUCTION.**—This section shall not be construed—

(1) to require a health information trustee to disclose protected health information; or

(2) to limit the right of a health information trustee to charge a fee for the disclosure or reproduction of protected health information.

(h) **SUBPOENAS, WARRANTS, AND SEARCH WARRANTS.**—If a health information trustee discloses protected health information pursuant to an authorization in order to comply with an administrative subpoena or warrant or a judicial subpoena or search warrant, the authorization—

(1) shall specifically authorize the disclosure for the purpose of permitting the trustee to comply with the subpoena, warrant, or search warrant; and

(2) shall otherwise meet the requirements in this section.

SEC. 9051. INSPECTION OF PROTECTED HEALTH INFORMATION.

(a) **IN GENERAL.**—Except as provided in subsection (b), a health information trustee—

(1) shall permit an individual to inspect any protected health information about the individual that the trustee maintains;

(2) shall permit the individual to have a copy of the information;

(3) shall permit a person who has been designated in writing by the individual to inspect, or to have a copy of, the information on behalf of the individual or to accompany the individual during the inspection; and

(4) may offer to explain or interpret information that is inspected or copied under this subsection.

(b) **EXCEPTIONS.**—A health care provider is not required by this section to permit inspection or copying of protected health information if any of the following conditions apply:

(1) **MENTAL HEALTH TREATMENT NOTES.**—The information consists of psychiatric, psychological, or mental health treatment notes, the provider determines in the exercise of reasonable medical judgment that inspection or copying of the notes would cause sufficient harm to the individual who is the subject of the notes so as to outweigh the desirability of permitting access, and the provider does not disclose the notes to any person not directly engaged in treating the individual, except with the authorization of the individual or under compulsion of law.

(2) **INFORMATION ABOUT OTHERS.**—The information relates to an individual other than the individual seeking to inspect or have a copy of the information and the provider determines in the exercise of reasonable medical judgment that inspection or copying of the information would cause sufficient harm to one or both of the individuals so as to outweigh the desirability of permitting access.

(3) **ENDANGERMENT TO LIFE OR SAFETY.**—Disclosure of the information could reasonably be expected to endanger the life or physical safety of an individual.

(4) **CONFIDENTIAL SOURCE.**—The information identifies or could reasonably lead to the identification of an individual (other than a health care provider) who provided information under a promise of confidentiality to a health care provider concerning the individual who is the subject of the information.

(5) **ADMINISTRATIVE PURPOSES.**—The information—

(A) is used by the provider solely for administrative purposes and not in the provision of health care to the individual who is the subject of the information; and

(B) is not disclosed by the provider to any person.

(c) **INSPECTION AND COPYING OF SEGREGABLE PORTION.**—A health information trustee shall permit inspection and copying under subsection (a) of any reasonably segregable portion of a record after deletion of any portion that is exempt under subsection (b).

(d) **CONDITIONS.**—A health information trustee may—

(1) require a written request for the inspection and copying of protected health information under this section; and

(2) charge a reasonable fee (not greater than the actual cost) for—

(A) permitting inspection of information under this section; and

(B) providing a copy of protected health information under this section.

(e) **STATEMENT OF REASONS FOR DENIAL.**—If a health information trustee denies a request for inspection or copying under this section, the trustee shall provide the individual who made the request (or the individual's designated representative) with a written statement of the reasons for the denial within the 30-day period beginning on the date the request is received.

SEC. 9052. AMENDMENT OF PROTECTED HEALTH INFORMATION.

(a) **IN GENERAL.**—A health information trustee shall, within the 45-day period beginning on the date the trustee receives from an individual about whom the trustee maintains protected health information a written request that the trustee correct or amend the information, either—

(1) make the correction or amendment requested, inform the individual of the correction or amendment that has been made, and inform any person who is identified by the individual and to whom the uncorrected or unamended portion of the information was previously disclosed of the correction or amendment that has been made; or

(2) inform the individual of—

(A) the reasons for the refusal of the trustee to make the correction or amendment;

(B) any procedures for further review of the refusal; and

(C) the individual's right to file with the trustee a concise statement setting forth the requested correction or amendment and the individual's reasons for disagreeing with the refusal of the trustee.

(b) **BASES FOR REQUEST TO CORRECT OR AMEND.**—An individual may request correction or amendment of protected health information about the individual under subsection (a) if the information is not timely, accurate, relevant, or complete.

(c) **STATEMENT OF DISAGREEMENT.**—After an individual has filed a statement of disagreement under subsection (a)(2)(C), the trustee, in any subsequent disclosure of the disputed portion of the information, shall include a copy of the individual's statement and may include a concise statement of the trustee's reasons for not making the requested correction or amendment.

(d) **CONSTRUCTION.**—This section shall not be construed to require a health information trustee to conduct a formal, informal, or other hearing or proceeding concerning a request for a correction or amendment to protected health information the trustee maintains.

(e) **CORRECTION.**—For purposes of subsection (a), a correction is deemed to have been made to protected health information where information that is not timely, accurate, relevant, or complete is clearly marked as incorrect or where supplementary correct information is made part of the information.

SEC. 9053. ENSURING APPROPRIATE SAFEGUARDS.

(a) **IN GENERAL.**—A health information trustee shall create and maintain, with respect to any protected health information the trustee discloses, a record of—

(1) the date and purpose of the disclosure;

(2) the name of the person to whom the disclosure was made;

(3) the address of the person to whom the disclosure was made or the location to which the disclosure was made; and

(4) the information disclosed, but only where the recording of the information disclosed is practicable, taking into account the technical capabilities of the system used to maintain the record and the costs of such maintenance.

(b) **DISCLOSURE RECORD PART OF INFORMATION.**—A record created and maintained under subsection (a) shall be maintained as part of the protected health information to which the record pertains.

(c) **ADMINISTRATIVE, TECHNICAL, AND PHYSICAL SAFEGUARDS.**—A health information trustee shall maintain reasonable and appropriate administrative, technical, and physical safeguards—

(1) to ensure the integrity and confidentiality of protected health information created or received by the trustee;

(2) to protect against any anticipated threats or hazards to the security or integrity of, improper disclosures of, or unauthorized uses of, such information; and

(3) otherwise ensure compliance with this Act by the trustee and the officers and employees of the trustee.

(d) **SPECIFIC SECURITY MEASURES.**—A health information trustee shall ensure that—

(1) officers, employees, and affiliated persons of the trustee who have access to protected health information created or received by the trustee are regularly trained in the requirements governing such information;

(2) audit trails are maintained, but only where the maintenance of such trails is practicable, taking into account the technical capabilities of the system used to maintain protected health information and the costs of such maintenance; and

(3) appropriate signs and warnings are posted to advise persons described in paragraph (1) regarding the need to secure protected health information.

SEC. 9054. CIVIL MONEY PENALTIES.

(a) **VIOLATION.**—Any health information trustee who the Secretary determines has substantially failed to comply with the provisions of this Act shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than \$10,000 for each such violation.

(b) **PROCEDURES FOR IMPOSITION OF PENALTIES.**—The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply to the imposition of a civil monetary penalty under this section in the same manner as such provisions apply with respect to the imposition of a penalty under section 1128A of such Act.

SEC. 9055. CIVIL ACTIONS.

(a) **IN GENERAL.**—Any individual whose rights under this title have been knowingly or negligently violated by a health information trustee, or any other person, may maintain a civil action for actual damages and for equitable relief against the health information trustee or other person.

(b) **ACTUAL DAMAGES.**—For purposes of this section, the term “actual damages” includes damages paid to compensate an individual for nonpecuniary losses such as physical and mental injury as well as damages paid to compensate for pecuniary losses.

(c) **PUNITIVE DAMAGES; ATTORNEY’S FEES.**—In any action brought under this section in which the complainant has prevailed because of a knowing violation of a provision of this title, the court may, in addition to any relief awarded under subsections (a) and (b), award such punitive damages as may be warranted. In such an action, the court, in its discretion, may allow the prevailing party a reasonable attorney’s fee (including expert fees) as part of the costs, and the United States shall be liable for costs the same as a private person.

(d) **LIMITATION.**—An individual may not bring a civil action under this section unless the action is brought within the 2-year period beginning on the date the act complained of occurred or was discovered by the individual.

SEC. 9056. AMENDMENTS TO TITLE 5, UNITED STATES CODE.

(a) **NEW SUBSECTION.**—Section 552a of title 5, United States Code, is amended by adding at the end the following:

“(w) **MEDICAL EXEMPTIONS.**—The head of an agency that is a health information trustee (as defined in section 3(b)(3) of the Fair Health Information Practices Act of 1994) shall promulgate rules, in accordance with the requirements (including general notice) of subsections (b)(1), (b)(2), (b)(3), (c), and (e) of section 553 of this title, to exempt a system of records within the agency, to the extent that the system of records contains protected health information (as defined in section 3(a)(3) of such

Act), from all provisions of this section except subsections (e)(1), (e)(2), subparagraphs (A) through (C) and (E) through (I) of subsection (e)(4), and subsections (e)(5), (e)(6), (e)(9), (e)(12), (l), (m), (n), (o), (p), (q), (r), and (u)."

(b) REPEAL.—Section 552a(f)(3) of title 5, United States Code, is amended by striking "pertaining to him," and all that follows through the semicolon and inserting "pertaining to the individual;".

SEC. 9057. DEFINITIONS.

For purposes of this part:

(1) HEALTH CARE PROVIDER.—The term "health care provider" includes a provider of services (as defined in section 1861(u) of the Social Security Act), a physician, a laboratory (as defined in section 353(a) of the Public Health Service Act), a supplier, and any other person furnishing health care. Such term includes a Federal or State program that provides directly for the provision of health care to beneficiaries.

(2) HEALTH INFORMATION TRUSTEE.—The term "health information trustee" means an individual who, or an entity that, creates, collects, maintains, receives, or uses protected health information.

(3) HEALTH OVERSIGHT AGENCY.—The term "health oversight agency" means a person—

(A) who performs or oversees the performance of an assessment, evaluation, determination, or investigation relating to the licensing, accreditation, or certification of health care providers;

(B) who—

(i) enters into agreements with health plan sponsor that provide health plans to individuals residing in a specific geographic region in order to facilitate the enrollment of such individuals in such plans; and

(ii) is a public agency, acting on behalf of a public agency, acting pursuant to a requirement of a public agency, a health alliance, or carrying out activities under a State or Federal statute regulating the agreements; or

(C) who—

(i) performs or oversees the performance of an assessment, evaluation, determination, or investigation relating to the effectiveness of, compliance with, or applicability of, legal, fiscal, medical, or scientific standards or aspects of performance related to the delivery of, or payment for, health care; and

(ii) is a public agency, acting on behalf of a public agency, acting pursuant to a requirement of a public agency, or carrying out activities under a State or Federal statute regulating the assessment, evaluation, determination, or investigation.

(4) HEALTH PLAN.—The term "health plan" has the meaning given such term in section 2204(4) of the Social Security Act and includes plans described in section 2204(3)(B) of such Act insofar as such plans provide payments for health care or medical benefits (as defined by the Secretary).

(5) HEALTH PLAN SPONSOR.—The term "health plan sponsor" has the meaning given the term "sponsor" in section 2204(12) of the Social Security Act in relation to a health plan (as defined in paragraph (4) of this section).

(6) INSTITUTIONAL REVIEW BOARD.—The term "institutional review board" means—

(A) a board established in accordance with regulations of the Secretary under section 491(a) of the Public Health Service Act;

(B) a similar board established by the Secretary for the protection of human subjects in research conducted by the Secretary;

(C) a similar board established under regulations of a Federal Government authority other than the Secretary; or

(D) a similar board which meets such requirements as the Secretary may specify.

(7) PROTECTED HEALTH INFORMATION.—

(A) IN GENERAL.—The term "protected health information" means any information, whether oral or recorded in any form or medium, that relates to the past, present, or future physical or mental health of an individual, the provision of health care to an individual, or payment for the provision of health care to an individual and—

(i) identifies the individual; or

(ii) with respect to which there is a reasonable basis to believe that the information can be used readily to identify the individual.

(B) SOCIAL SECURITY NUMBER.—Such term includes the social security account number of any individual.

SEC. 9058. EFFECTIVE DATES.

(a) IN GENERAL.—Except as provided in subsection (b), this part, and the amendments made by this part, shall take effect on January 1, 1996.

(b) PROVISIONS EFFECTIVE IMMEDIATELY.—Any provision of this part that imposes a duty on the Secretary shall take effect on the date of the enactment of this Act.

SEC. 9059. RELATIONSHIP TO OTHER LAWS.

(a) STATE LAW.—Except as provided in subsections (b) and (c), this part shall prevent the establishment, continuing in effect, or enforcement of State law to the extent such law is inconsistent with a provision of this part, but nothing in this part shall be construed to indicate an intent on the part of Congress to occupy the field in which its provisions operate to the exclusion of the laws of any State on the same subject matter.

(b) PRIVILEGES.—This part does not preempt or modify State common or statutory law to the extent such law concerns a privilege of a witness or person in a court of the State. This part does not supersede or modify Federal common or statutory law to the extent such law concerns a privilege of a witness or person in a court of the United States.

(c) CERTAIN DUTIES UNDER STATE OR FEDERAL LAW.—This part shall not be construed to preempt, supersede, or modify the operation of—

(1) any law that provides for the reporting of vital statistics such as birth or death information;

(2) any law requiring the reporting of abuse or neglect information about any individual; or

(3) subpart II of part E of title XXVI of the Public Health Service Act (relating to notifications of emergency response employees of possible exposure to infectious diseases).

Subtitle B—Information Systems and Administrative Simplification

SEC. 9101. REQUIREMENT FOR HEALTH SECURITY CARDS.

(a) HEALTH SECURITY CARDS.—

(1) REQUIREMENT.—Each health benefit plan sponsor shall issue a health security card that meets the requirements of subsection (c) for each individual who is entitled to benefits under a health benefit plan provided or sponsored by the sponsor if the plan is the medicare program or provides for coverage of the guaranteed national benefit package. Such card shall be issued to the individual involved or, in the case of an individual enrolled as a dependent of another individual, to that other individual.

(2) DEADLINE FOR APPLICATION OF REQUIREMENT.—The deadline specified under this paragraph for the requirement under paragraph (1) is 12 months after the date the standards are established under subsection (c).

(b) ENFORCEMENT THROUGH CIVIL MONEY PENALTIES.—

(1) IN GENERAL.—In the case of a health benefit plan sponsor that fails to issue a health security card in accordance with subsection (a)(1), the sponsor is subject to a civil money penalty of not to exceed \$100 for each such violation. The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply to a civil money penalty under this subsection in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(2) EFFECTIVE DATE.—No penalty may be imposed under paragraph (1) for any failure occurring before the deadline specified in subsection (a)(2).

(c) HEALTH SECURITY CARDS.—

(1) IN GENERAL.—The Secretary shall establish standards consistent with this subsection respecting the form and information to be contained on health security cards (for purposes of subsection (a)).

(2) ELECTRONIC.—

(A) IN GENERAL.—Subject to subparagraph (B), the card shall be in a form similar to that of a credit card and shall have, encoded in electronic form—

(i) the identity of the individual entitled to health benefits;

(ii) the health benefit plan in which the individual is enrolled;

(iii) the identity of each principal insured (as defined by the Secretary) for the family that includes the individual, in the case of an individual who is enrolled under a family class of enrollment;

(iv) the telephone number or numbers to be used for the submission electronically of claims under the plan under section 9103; and

(v) information relating to organ donation.

(B) **USE OF ELECTRONIC READ-AND-WRITE CARDS.**—The Secretary may provide for cards in an electronic form that permits information on the card to be readily changed. Such information may include information relating to the health coverage status of the individual and the medical history of the individual.

(C) **PERSONAL IDENTIFIER.**—For purposes of subparagraph (A) and for purposes of claims processing and related purposes under section 9103, the Social Security account number of the individual or, in the case of an infant or other individual to whom such a number has not been issued, such a Social Security account number of a parent or guardian or other number as the Secretary shall specify, shall be used as the personal identifier for the individual.

(3) **ADDITIONAL INFORMATION.**—The card shall include such additional information, in electronic or other form, as the Secretary may require to carry out the purposes of this Act. In addition, the health benefit plan sponsor issuing the card may include such additional information on the card as the sponsor desires, subject to such limitations as the Secretary may provide.

(4) **PERMISSIBLE USES OF CARD.**—A health security card that is issued to an individual who is entitled to benefits under a health benefit plan may be used by an individual or entity only for the purpose of providing or assisting the individual entitled to benefits in obtaining an item or service that is covered under such plan.

(5) **DEADLINE.**—The Secretary shall first establish the standards for health security cards under this subsection by not later than 18 months after the date of the enactment of this Act.

(d) **APPLICATION TO MEDICARE AND MEDICAID PROGRAM.**—

(1) **MEDICARE PROGRAM.**—The Secretary shall provide, in regulations promulgated to carry out the medicare program, that identification cards issued under that program are modified to the extent required to conform to the standards established under subsection (c), by not later than the deadline specified in subsection (a)(2).

(2) **STATE MEDICAID PLANS.**—As a condition for the approval of a State plan under the medicaid program, effective for calendar quarters beginning on or after the deadline specified in subsection (a)(2), each such plan shall provide, in accordance with regulations of the Secretary, that identification cards issued under the plan are modified to the extent required to conform to subsection (c).

SEC. 9102. NATIONAL ENROLLMENT VERIFICATION SYSTEM.

(a) **ESTABLISHMENT.**—The Secretary shall establish a national enrollment verification system for the verification of an individual's enrollment in a health benefit plan and entitlement to benefits under such plan. The system shall assist in the identification of, and collection from, parties responsible for the payment for health care items and services furnished to individuals enrolled under a health benefit plan.

(b) **INFORMATION IN SYSTEM.**—The enrollment verification system shall contain such information submitted by health benefit plan sponsors, employers, and other individuals and entities specified by the Secretary as the Secretary shall determine in standards established under this section. The information shall include the following with respect to each individual enrolled in a health benefit plan (regardless of whether the individual is enrolled under an individual or a family class of enrollment):

(1) The name, address, and personal identifier of the individual and the identity of each principal insured (as defined by the Secretary under section 9101(c)(2)(A)(iii)) for the family that includes the individual, in the case of an individual who is enrolled under a family class of enrollment.

(2) The name, address, and telephone number of each health benefit plan in which the individual is enrolled.

(3) The type of coverage elected.

(4) Race and ethnicity data.

(5) The period for which such coverage is elected.

(6) The status of individuals with respect to deductibles, copayments, coinsurance, or out-of-pocket limits on cost sharing.

(7) Coordination of benefit information appropriate in determining liability in cases in which benefits may be payable under 2 or more health benefit plans.

(c) PERIODICITY OF SUBMISSIONS.—The standards established by the Secretary under this subsection shall require the submission of information to the national enrollment verification system on a periodic basis (as determined by the Secretary) in order to report applicable changes with respect to enrollment status or eligibility.

(d) FORM OF INQUIRY.—The verification system shall be capable of accepting inquiries from health care providers, health benefit plan sponsors (and any other individual or entity determined appropriate by the Secretary) in a variety of electronic and other forms, including—

- (1) through electronic transmission of information on the health security card (in a manner similar to that for verification of credit card purchases);
- (2) through the use of a touch-tone telephone line; and
- (3) through the use of a computer modem.

(e) FORM OF RESPONSE.—The system shall be capable of responding to inquiries under subsection (d) in a variety of electronic and other forms, including—

- (1) through modem transmission of information;
- (2) through computer synthesized voice communication; and
- (3) through transmission of information to a facsimile (fax) machine.

(f) LIMITS ON DISCLOSURE OF INFORMATION REPORTED.—The disclosure of information reported to the national enrollment verification system shall be restricted by the Secretary under standards established by the Secretary that are consistent with part 4 of subtitle A.

(g) FEES.—The Secretary may impose a fee for the acceptance of, or response to, an inquiry to the verification system.

(h) PUBLIC DOMAIN SOFTWARE TO PROVIDERS.—The Secretary shall provide for the development, and shall make available without charge to health care providers, such computer software as will enable such providers to make inquiries to, and receive responses from, the national enrollment verification system in electronic form.

(i) DEADLINE.—The Secretary shall establish the system and standards under this section (and shall develop and make available the software under subsection (h)) by not later than 12 months after the date of the enactment of this Act.

(j) CIVIL MONEY PENALTY.—In the case of a failure of an individual or entity to report information to the enrollment verification system under a standard established by the Secretary under this section, the individual or entity shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than \$100 for each day in which such failure persists. The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply to a civil money penalty under this subsection in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(k) ELIMINATION OF EMPLOYER REQUIREMENT TO REPORT CERTAIN INFORMATION TO MEDICARE AND MEDICAID COVERAGE DATA BANK.—Effective upon full implementation of the national enrollment verification system under this section—

- (1) no employer is required to make any reports under section 1144(c) of the Social Security Act; and
- (2) information and functions previously in or performed by the Medicare and Medicaid Coverage Data Bank under section 1144 of such Act shall be subsumed by the enrollment verification system.

SEC. 9103. REQUIREMENTS FOR UNIFORM CLAIMS AND ELECTRONIC CLAIMS DATA SET.

(a) REQUIREMENTS.—

(1) SUBMISSION OF CLAIMS.—Each health care provider that furnishes services in the United States for which payment may be made under a health benefit plan shall submit any claim for payment for such services only in a form and manner consistent with the standards established under subsection (c).

(2) ACCEPTANCE OF CLAIMS.—A health benefit plan sponsor may not reject a claim for payment under the health benefit plan provided on the basis of the form or manner in which the claim is submitted if the claim is submitted in accordance with the standards established under subsection (c).

(3) EFFECTIVE DATE.—This subsection shall apply to claims for services furnished on or after the date that is 6 months after the date standards are established under subsection (c).

(b) ENFORCEMENT THROUGH CIVIL MONEY PENALTIES.—

(1) IN GENERAL.—

(A) PROVIDERS.—In the case of a health care provider that submits a claim in violation of subsection (a)(1), the provider is subject to a civil

money penalty of not to exceed \$100 (or, if greater, the amount of the claim) for each such violation.

(B) HEALTH BENEFIT PLAN SPONSORS.—In the case of a health benefit plan sponsor that rejects a claim in violation of subsection (a)(2), the sponsor is subject to a civil money penalty of not to exceed \$100 (or, if greater, the amount of the claim) for each such violation.

(2) PROCESS.—The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply to a civil money penalty under paragraph (1) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(c) STANDARDS RELATING TO UNIFORM CLAIMS AND ELECTRONIC CLAIMS DATA SET.—

(1) ESTABLISHMENT OF STANDARDS.—The Secretary shall establish standards that relate to the form and manner of submission of claims for benefits under a health benefit plan. The standards—

(A) shall require that such claims be submitted electronically;

(B) shall define the data elements to be contained in a uniform electronic claims data set to be used with respect to such claims;

(C) establish a uniform electronic format for the electronic transmission of such elements;

(D) shall include instructions on record keeping in support of claims submitted; and

(E) shall ensure the suitability of electronic data as evidence in a court of law.

(2) SCOPE OF INFORMATION.—

(A) IN GENERAL.—The standards under this subsection are intended to cover substantially most claims that are filed under health benefit plans. Such information need not include all elements that may potentially be required to be reported under utilization review provisions of plans.

(B) ENSURING ACCOUNTABILITY FOR CLAIMS SUBMITTED ELECTRONICALLY.—In establishing such standards, the Secretary, in consultation with appropriate agencies, shall include such methods of ensuring provider responsibility and accountability for claims submitted electronically that are designed to control fraud and abuse in the submission of such claims.

(C) COMPONENTS.—In establishing such standards the Secretary shall—

(i) with respect to data elements, define data fields, formats, and medical nomenclature, and plan benefit and insurance information; and

(ii) develop a single, uniform, up-to-date coding system for procedures, services, and diagnoses based, to the maximum extent possible, on the American Medical Association's Common Procedural Terminology, Fourth Edition or a revised version of such text (with respect to procedures and services) and the International Classification of Diseases, 9th Revision, Clinical Modification, Third Edition or a revised version of such text (with respect to diagnoses), with additional coding developed as necessary by the Secretary.

(3) COORDINATION WITH STANDARDS FOR ELECTRONIC MEDICAL RECORDS.—In establishing standards under this subsection, the Secretary shall assure that—

(A) the development of such standards is coordinated with the development of the standards for reporting uniform clinical data sets under section 9104; and

(B) the coding of data elements under the uniform electronic claims data set and the coding of the same elements in the uniform hospital clinical data set and the uniform patient information data set developed under section 9104 are consistent.

(4) UNIFORM, UNIQUE PROVIDER IDENTIFICATION CODES.—In establishing standards under this subsection—

(A) the Secretary shall provide for a unique identifier code for each health care provider and group practice that furnishes services for which a claim may be submitted under a health benefit plan; and

(B) in the case of a provider that has a unique identifier issued for purposes of the medicare program, the code provided under subparagraph (A) shall be the same as such unique identifier.

(5) PUBLIC DOMAIN SOFTWARE TO PROVIDERS.—The Secretary shall provide for the development, and shall make available without charge to health care providers, such computer software as will enable the providers to submit claims and to receive verification of claims status electronically.

(6) STANDARDS FOR CLAIMS FOR CLINICAL LABORATORY TESTS.—The standards shall provide that claims for clinical laboratory tests for which benefits are pro-

vided under a health benefit plan shall be submitted directly by the person or entity that performed (or supervised the performance of) the tests to the plan in a manner consistent with (and subject to such exceptions as are provided under) the requirement for direct submission of such claims under the medicare program.

(7) DEADLINE.—The Secretary shall first provide for the standards for the uniform claims under this subsection (and shall develop and make available the software under paragraph (6)) by not later than 1 year after the date of the enactment of this Act.

(d) USE UNDER MEDICARE AND MEDICAID PROGRAMS.—

(1) REQUIREMENT FOR PROVIDERS.—In the case of a health care provider that submits a claim for services furnished under the medicare program or medicaid program in violation of subsection (a)(1), no payment shall be made under such program for such services.

(2) REQUIREMENTS OF INTERMEDIARIES AND CARRIERS UNDER MEDICARE PROGRAM.—The Secretary shall provide, in regulations promulgated to carry out title XVIII of the Social Security Act, that the claims process provided under that title is modified to the extent required to conform to the standards established under subsection (c).

(3) REQUIREMENTS OF STATE MEDICAID PLANS.—As a condition for the approval of State plans under the medicaid program, effective as of the effective date specified in subsection (a)(3), each such plan shall provide, in accordance with regulations of the Secretary, that the claims process provided under the plan is modified to the extent required to conform to the standards established under subsection (c).

SEC. 9104. REPORTING OF UNIFORM CLINICAL DATA SETS.

(a) STANDARDS FOR ELECTRONIC REPORTING OF UNIFORM CLINICAL DATA SETS.—

(1) PROMULGATION OF STANDARDS.—

(A) IN GENERAL.—Not later than the deadlines provided in paragraph (5), the Secretary shall promulgate standards described in paragraph (2) concerning the uniform clinical data sets described in such paragraph.

(B) REVISION.—The Secretary may from time to time revise the standards promulgated under this paragraph.

(2) CONTENTS OF STANDARDS.—The standards promulgated under paragraph

(1) shall include at least the following:

(A) A definition of a uniform hospital clinical data set, including a definition of the set of comprehensive data elements, for use by utilization and quality control peer review organizations.

(B) A definition of a uniform patient information data set including data obtained at the point of care, for use by utilization and quality control peer review organizations with respect to physician care.

(C) A specification of, and manner of presentation of, the individual data elements of the sets under this paragraph.

(D) Standards concerning the electronic transmission of such data sets.

(E) Standards consistent with part 4 of subtitle A relating to confidentiality of protected health information (as defined in such part) reported under this section, which include the physical security of electronic data and the use of keys, passwords, encryption, and other means to ensure the protection of the confidentiality and privacy of electronic data.

(F) Standards to ensure the suitability of electronic data as evidence in a court of law.

(3) COORDINATION WITH STANDARDS FOR UNIFORM ELECTRONIC CLAIMS DATA SET.—In establishing standards under this subsection, the Secretary shall ensure that—

(A) the development of the standards is coordinated with the development of the standards for the uniform electronic claims data set under section 9103;

(B) the coding of the same data elements under the uniform hospital clinical data set, the uniform patient information data set, and the uniform electronic claims data set is consistent; and

(C) the standards under this subsection are consistent, to the maximum extent practicable, with other standards existing at the time the standards under this subsection are established, including any standard set by the American National Standards Institute.

(4) CONSULTATION.—in establishing standards under this subsection, the Secretary shall—

(A) consult with the National Health Care Quality Advisory Commission established under section 9012, the American National Standards Institute, health care providers, health benefit plan sponsors, and other interested parties; and

(B) take into consideration the data set used by the utilization and quality control peer review program under part B of title XI of the Social Security Act.

(5) DEADLINES.—The Secretary shall promulgate standards described in paragraph (2) concerning the uniform hospital clinical data set prior to the expiration of the 1-year period beginning on the date of the enactment of this Act. The Secretary shall promulgate standards described in paragraph (2) concerning the uniform patient information clinical data set prior to January 1, 2000.

(b) REQUIREMENT FOR APPLICATION OF ELECTRONIC RECORDS STANDARDS TO HOSPITALS.—

(1) AS CONDITION OF MEDICARE PARTICIPATION.—As of January 1, 2000, each hospital, as a requirement of each participation agreement under section 1866 of the Social Security Act, shall, in accordance with the standards promulgated under subsection (a)(1)—

(A) maintain clinical data included in the uniform hospital clinical data set under subsection (a)(2)(A) in electronic form on all inpatients;

(B) upon request of the Secretary or of a utilization and quality control peer review organization (with which the Secretary has entered into a contract under part B of title XI of such Act), transmit electronically data requested from such data set; and

(C) upon request of the Secretary, or of a fiscal intermediary or carrier, transmit electronically any data (with respect to a claim) from such data set.

(2) APPLICATION OF PRESENTATION AND TRANSMISSION STANDARDS TO ELECTRONIC TRANSMISSION TO FEDERAL AGENCIES.—Effective January 1, 2000, if a hospital is required under a Federal program to transmit a data element included in the uniform hospital clinical data set that is subject to a standard, promulgated under subsection (a)(1), described in subparagraph (C) or (D) of subsection (a)(2), the head of the Federal agency responsible for such program (if not otherwise authorized) is authorized to require the provider to present and transmit the data element electronically in accordance with such a standard.

(c) LIMITATION ON DATA REQUIREMENTS WHERE STANDARDS IN EFFECT.—

(1) IN GENERAL.—On or after January 1, 2000, a health benefit plan sponsor may not require, for the purpose of utilization review or as a condition of providing benefits or making payments under the plan provided, that a hospital—

(A) provide any data element not in the uniform hospital clinical data set specified under the standards promulgated under subsection (a); or

(B) transmit or present any such data element in a manner inconsistent with such standards applicable to such transmission or presentation.

(2) COMPLIANCE.—The Secretary may impose a civil money penalty on any health benefit plan sponsor that fails to comply with paragraph (1) in an amount not to exceed \$100 for each such failure. The provisions of section 1128A of the Social Security Act (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(3) APPLICATION TO MEDICARE PROGRAM.—Effective as of January 1, 2000, neither the Secretary, nor any carrier or fiscal intermediary, nor any utilization and quality control peer review organization may require, for the purpose of utilization review or as a condition of providing benefits or making payments under the medicare program, that a hospital—

(A) provide any data element not in the uniform hospital clinical data set specified under the standards promulgated under subsection (a); or

(B) transmit or present any such data element in a manner inconsistent with such standards applicable to such transmission or presentation.

(4) APPLICATION TO MEDICAID PROGRAM.—As a condition for the approval of State plans under the medicaid program and in accordance with regulations of the Secretary, effective as of January 1, 2000, each such plan may not require that a hospital, for the purpose of utilization review or as a condition of providing benefits or making payments under the plan—

(A) provide any data element not in the uniform hospital clinical data set specified under the standards promulgated under subsection (a), or

(B) transmit or present any such data element in a manner inconsistent with such standards applicable to such transmission or presentation.

(d) **PREEMPTION OF STATE QUILL PEN LAWS.**—

(1) **IN GENERAL.**—Any provision of State law that requires medical or health insurance records (including billing information) to be maintained in written, rather than electronic, form is deemed to be satisfied if the records are maintained in an electronic form that meets standards established by the Secretary under paragraph (2).

(2) **SECRETARIAL AUTHORITY.**—Not later than 1 year after the date of the enactment of this Act, the Secretary shall issue regulations to carry out paragraph (1). The regulations shall provide for an electronic substitute that is in the form of a unique identifier (assigned to each authorized individual) that serves the functional equivalent of a signature. The regulations may provide for such exceptions to paragraph (1) as the Secretary determines to be necessary to prevent fraud and abuse, to prevent the illegal distribution of controlled substances, and in such other cases as the Secretary deems appropriate.

(3) **EFFECTIVE DATE.**—Paragraph (1) shall take effect on the first day of the first month that begins more than 30 days after the date the Secretary issues the regulations referred to in paragraph (2).

SEC. 9105. UNIFORM HOSPITAL COST REPORTING.

Each hospital, as a requirement under a participation agreement under section 1866(a) of the Social Security Act for each cost reporting period beginning during or after fiscal year 1995, shall provide for the reporting of information to the Secretary with respect to any hospital care provided in a uniform manner consistent with standards established by the Secretary to carry out section 4007(c) of the Omnibus Budget Reconciliation Act of 1987 and in an electronic form consistent with standards established by the Secretary.

SEC. 9106. USE OF TASK FORCES.

In adopting standards under this subtitle, the Secretary—

(1) shall take into account the recommendations of—

(A) current task forces, including at least the Workgroup on Electronic Data Interchange, National Uniform Billing Committee, the Uniform Claim Task Force, and the Computer-based Patient Record Institute; and

(B) national organizations representing health care financial managers; and

(2) shall provide that electronic transmission standards are consistent, to the extent practicable, with the applicable standards established by the Accredited Standards Committee X-12 of the American National Standards Institute.

SEC. 9107. DEFINITIONS.

For purposes of this subtitle:

(1) **HEALTH BENEFIT PLAN.**—The term “health benefit plan” has the meaning given such term in section 2204(3) of the Social Security Act and includes—

(A) the medicare program, medicare supplemental health insurance, medicare part C, the medicaid program, the wrap around benefit program under subpart 2 of part B of title XXIII of such Act, and

(B) except as the Secretary may provide, other Federal or State programs that provide for payments for health care services (other than coverage or insurance described in clause (i) or clauses (iii) through (ix) of section 2204(3)(B) of such Act).

(2) **HEALTH BENEFIT PLAN SPONSOR.**—The term “health benefit plan sponsor” has the meaning given the term “sponsor” in section 2204(12) of the Social Security Act in relation to a health benefit plan (as defined in paragraph (1)).

(3) **HEALTH CARE PROVIDER.**—The term “health care provider” has the meaning given such term in section 9057(1). Such term includes a Federal or State program that provides directly for the provision of health services to beneficiaries.

Subtitle C—Fraud and Abuse

PART 1—AMENDMENTS TO ANTI-FRAUD AND ABUSE PROVISIONS APPLICABLE TO MEDICARE, MEDICAID, AND STATE HEALTH CARE PROGRAMS

SEC. 9201. ANTI-KICKBACK STATUTORY PROVISIONS.

(a) REVISION TO PENALTIES.—

(1) PERMITTING SECRETARY TO IMPOSE CIVIL MONETARY PENALTY.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a-7a(a)) is amended—

(A) by striking “or” at the end of paragraphs (1) and (2);

(B) by striking the semicolon at the end of paragraph (3) and inserting “; or”; and

(C) by inserting after paragraph (3) the following new paragraph:

“(4) carries out any activity in violation of paragraph (1) or (2) of section 1128B(b);”.

(2) DESCRIPTION OF CIVIL MONETARY PENALTY APPLICABLE.—Section 1128A(a) of such Act (42 U.S.C. 1320a-7a(a)) is amended—

(A) by striking “given.” at the end of the first sentence and inserting the following: “given or, in cases under paragraph (4), \$50,000 for each such violation.”; and

(B) by striking “claim.” at the end of the second sentence and inserting the following: “claim (or, in cases under paragraph (4), damages of not more than three times the total amount of remuneration offered, paid, solicited, or received.”.

(3) INCREASE IN CRIMINAL PENALTY.—Paragraphs (1) and (2) of section 1128B(b) of such Act (42 U.S.C. 1320a-7b(b)) are each amended—

(A) by striking “\$25,000” and inserting “\$50,000”; and

(B) by striking the period at the end and inserting the following: “, and shall be subject to damages of not more than three times the total remuneration offered, paid, solicited, or received.”.

(b) REVISIONS TO EXCEPTIONS.—

(1) EXCEPTION FOR DISCOUNTS.—Section 1128B(b)(3)(A) of such Act (42 U.S.C. 1320a-7b(b)(3)(A)) is amended by striking “program,” and inserting “program and is not in the form of a cash payment;”.

(2) EXCEPTION FOR PAYMENTS TO EMPLOYEES.—Section 1128B(b)(3)(B) of such Act (42 U.S.C. 1320a-7b(b)(3)(B)) is amended by inserting at the end “if the amount of remuneration under the arrangement is consistent with the fair market value of the services and is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals, except that such employee can be paid remuneration in the form of a productivity bonus based on services personally performed by the employee.”.

(3) EXCEPTION FOR WAIVER OF COINSURANCE BY CERTAIN PROVIDERS.—Section 1128B(b)(3)(D) of such Act (42 U.S.C. 1320a-7b(b)(3)(D)) is amended to read as follows:

“(D) a waiver or reduction of any coinsurance or other copayment if—

“(i) the waiver or reduction is made pursuant to a public schedule of discounts which the person is obligated as a matter of law to apply to certain individuals,

“(ii) the waiver or reduction is made pursuant to an established program and applies to a defined group of individuals whose incomes do not exceed 150 percent (or such higher percentage as the Secretary may permit) of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved,

“(iii) the waiver or reduction of coinsurance is not offered as part of any advertisement or solicitation and the person offering the waiver or reduction determines in good faith that the individual is in financial need,

“(iv) the person offering the waiver or reduction fails to collect the coinsurance or other payment after making reasonable collection efforts, or

“(v) the waiver or reduction of coinsurance is in accordance with a cost sharing schedule or a supplemental benefit package which may be offered by a managed care plan under title XXII; and”.

(4) NEW EXCEPTION FOR CAPITATED PAYMENTS.—Section 1128B(b)(3) of such Act (42 U.S.C. 1320a-7b(b)(3)) is amended—

(A) by striking “and” at the end of subparagraph (D);

(B) by striking the period at the end of subparagraph (E) and inserting “; and”; and

(C) by adding at the end the following new subparagraphs:

“(F) any reduction in cost sharing or increased benefits given to an individual, any amounts paid to a provider for an item or service furnished to an individual, or any discount or reduction in price given by the provider for such an item or service, if the individual is enrolled with and such item or service is covered under any of the following:

“(i) A health plan which is furnishing items or services under a risk-sharing contract under section 1876 or section 1903(m).

“(ii) A health plan receiving payments on a prepaid basis, under a demonstration project under section 402(a) of the Social Security Amendments of 1967 or under section 222(a) of the Social Security Amendments of 1972; and

“(G) any amounts paid to a provider for an item or service furnished to an individual or any discount or reduction in price given by the provider for such an item or service, if the individual is enrolled with and such item or service is covered under a health plan under which the provider furnishing the item or service is paid by the health plan for furnishing the item or service only on a capitated basis pursuant to a written arrangement between the plan and the provider in which the provider assumes financial risk for furnishing the item or service.”.

(c) **AUTHORIZATION FOR THE SECRETARY TO ISSUE REGULATIONS.**—Section 1128B(b) of such Act (42 U.S.C. 1320a-7b(b)) is amended by adding at the end the following new paragraph:

“(4) The Secretary is authorized to impose by regulation such other requirements as needed to protect against program or patient abuse with respect to any of the exceptions described in paragraph (3).”.

(d) **CLARIFICATION OF OTHER ELEMENTS OF OFFENSE.**—Section 1128B(b) of such Act (42 U.S.C. 1320a-7b(b)) is amended—

(1) in paragraph (1)(A), by striking “in return for referring” and inserting “to refer”;

(2) in paragraph (1)(B), by striking “in return for purchasing, leasing, ordering, or arranging for or recommending” and inserting “to purchase, lease, order, or arrange for or recommend”; and

(3) by adding at the end of paragraphs (1) and (2) the following sentence: “A violation exists under this paragraph if one or more purposes of the remuneration is unlawful under this paragraph.”.

SEC. 9202. CIVIL MONEY PENALTIES.

(a) **PROHIBITION AGAINST OFFERING INDUCEMENTS TO INDIVIDUALS ENROLLED UNDER PLANS.**—

(1) **OFFER OF REMUNERATION.**—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a-7a(a)), as amended by section 9201(a)(1), is amended—

(A) by striking “; or” at the end of paragraph (3) and inserting a semicolon;

(B) by striking the semicolon at the end of paragraph (4) and inserting “; or”; and

(C) by inserting after paragraph (4) the following new paragraph:

“(5) offers, pays, or transfers remuneration to any individual eligible for benefits under title XVIII of this Act, or under a State health care program (as defined in section 1128(h)) that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under title XVIII, or a State health care program, other than to influence an individual enrolled in a managed care plan or a point-of-service plan (as defined in section 2204) to receive benefits under the plan in accordance with established practice patterns for the delivery of medically necessary services;”.

(2) **REMUNERATION DEFINED.**—Section 1128A(i) of such Act (42 U.S.C. 1320a-7a(i)) is amended by adding at the end the following new paragraph:

“(6) The term ‘remuneration’ includes the waiver or reduction of coinsurance amounts, and transfers of items or services for free or for other than fair market value, except that such term does not include the waiver or reduction of coinsurance amounts by a person or entity, if—

"(A) the waiver or reduction is made pursuant to a public schedule of discounts which the person is obligated as a matter of law to apply to certain individuals,

"(B) the waiver or reduction is made pursuant to an established program and applies to a defined group of individuals whose incomes do not exceed 150 percent (or such higher percentage as the Secretary may permit) of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved,

"(C) the waiver or reduction of coinsurance is not offered as part of any advertisement or solicitation and the person offering the waiver or reduction determines in good faith that the individual is in financial need,

"(D) the person offering the waiver or reduction fails to collect the coinsurance or other payment after making reasonable collection efforts, or

"(E) the waiver or reduction of coinsurance is in accordance with a cost sharing schedule or a supplemental benefit package which may be offered by a managed care plan under title XXII."

(b) ADDITIONAL OFFENSES.—Section 1128A(a) of such Act, as amended by section 9201(a)(1) and subsection (a)(1), is further amended—

(1) by striking "or" at the end of paragraph (4);

(2) by striking the semicolon at the end of paragraph (5) and inserting "; or"; and

(3) by inserting after paragraph (5) the following new paragraphs:

"(6) engages in a practice which has the effect of limiting or discouraging (as compared to other plan enrollees) the utilization of medically necessary health care services covered by law or under the service contract by title XIX or other publicly subsidized patients, including but not limited to differential standards for the location and hours of service offered by providers participating in the plan;

"(7) substantially fails to cooperate with a quality assurance program or a utilization review activity;

"(8) engaging in a pattern of failing substantially to provide or authorize medically necessary items and services that are required to be provided to an individual covered under a health plan under the Health Security Act or public program for the delivery of or payment for health care items or services, if the failure has adversely affected (or had a substantial likelihood of adversely affecting) the individual; or

"(9) submits false or fraudulent statements, data or information on claims to the Secretary, a State health care agency, or any other Federal, State or local agency charged with implementation or oversight of a health plan or a public program that the person knows or should know is fraudulent;"

(c) MODIFICATIONS OF AMOUNTS OF PENALTIES AND ASSESSMENTS.—Section 1128A(a) of such Act (42 U.S.C. 1320a-7a(a)), as amended by section 9201(a), subsection (a)(1), and subsection (b), is amended in the matter following paragraph (9)—

(1) by striking "\$2,000" and inserting "\$10,000";

(2) by inserting after "under paragraph (4), \$50,000 for each such violation" the following: "; in cases under paragraph (5), \$10,000 for each such offer, payment, or transfer; in cases under paragraphs (6) through (9), an amount not to exceed \$10,000 for each such determination by the Secretary"; and

(3) by striking "twice the amount" and inserting "three times the amount".

(d) INTEREST ON PENALTIES.—Section 1128A(f) of such Act (42 U.S.C. 1320a-7a(f)) is amended by adding after the first sentence the following: "Interest shall accrue on the penalties and assessments imposed by a final determination of the Secretary in accordance with an annual rate established by the Secretary under the Federal Claims Collection Act. The rate of interest charged shall be the rate in effect on the date the determination becomes final and shall remain fixed at that rate until the entire amount due is paid. In addition, the Secretary is authorized to recover the costs of collection in any case where the penalties and assessments are not paid within 30 days after the determination becomes final, or in the case of a compromised amount, where payments are more than 90 days past due. In lieu of actual costs, the Secretary is authorized to impose a charge of up to 10 percent of the amount of penalties and assessments owed to cover the costs of collection."

(e) AUTHORIZATION TO ACT.—

(1) IN GENERAL.—The first sentence of section 1128A(c)(1) of such Act (42 U.S.C. 1320a-7a(c)(1)) is amended by striking all that follows "(b)" and inserting the following: "unless, within one year after the date the Secretary presents

a case to the Attorney General for consideration, the Attorney General brings an action in a district court of the United States.”.

(2) **EFFECTIVE DATE.**—The amendment made by this paragraph (1) shall apply to cases presented by the Secretary of Health and Human Services for consideration on or after the date of the enactment of this Act.

(f) **DEPOSIT OF PENALTIES COLLECTED INTO ALL-PAYER ACCOUNT.**—Section 1128A(f)(3) of such Act (42 U.S.C. 1320a-7a(f)(3)) is amended by striking “as miscellaneous receipts of the Treasury of the United States” and inserting “in the All-Payer Health Care Fraud and Abuse Control Account established under section 9212 of the Health Security Act”.

(g) **CLARIFICATION OF PENALTY IMPOSED ON EXCLUDED PROVIDER FURNISHING SERVICES.**—Section 1128A(a)(1)(D) of such Act (42 U.S.C. 1320a-7a(a)(1)(D)) is amended by inserting “who furnished the service” after “in which the person”.

SEC. 9203. PRIVATE RIGHT OF ACTION.

Section 1128A of the Social Security Act (42 U.S.C. 1320a-7a) is amended by adding at the end the following new subsection:

“(m)(1) Subject to paragraphs (2) and (3), a carrier offering an insured health plan and the sponsor of a self-insured health plan that suffers financial harm as a direct result of the submission of claims by an individual or entity for payment for items and services furnished under the plan which makes the individual or entity subject to a civil monetary penalty under this section or under title IX of the Health Security Act may, in a civil action against the individual or entity in the United States District Court, obtain damages against the individual or entity and such equitable relief as is appropriate.

“(2) A carrier or sponsor may bring a civil action under this subsection only if the carrier or sponsor provides the Secretary and the Attorney General with written notice of the intent to bring an action under this subsection, the identities of the individuals or entities the carrier or sponsor intends to name as defendants to the action, and all information the carrier or sponsor possesses regarding the activity that is the subject of the action that may materially affect the Secretary’s decision to initiate a proceeding to impose a civil monetary penalty under this section against the defendants.

“(3) A carrier or sponsor may bring a civil action under this subsection only if any of the following conditions are met:

“(A) During the 60-day period that begins on the date the Secretary receives the written notice described in paragraph (2), the Secretary does not notify the carrier or sponsor that the Secretary intends to initiate a proceeding to impose a civil monetary penalty under this section against the defendants.

“(B) If the Secretary notifies the carrier or sponsor during the 60-day period described in subparagraph (A) that the Secretary intends to initiate a proceeding to impose a civil monetary penalty under this section against the defendants, the Secretary subsequently notifies the carrier or sponsor that the Secretary no longer intends to initiate such a proceeding against the defendants.

“(C) After the expiration of the 2-year period that begins on the date the Secretary notifies the carrier or sponsor that the Secretary intends to initiate a proceeding to impose a civil monetary penalty under this section against the defendants, the Secretary has not made a good faith effort to initiate such a proceeding against the defendants.

“(4) If a carrier or sponsor is awarded any amounts in an action brought under this subsection that are in excess of the damages suffered by the carrier or sponsor as a result of the defendant’s activities, 10 percent of such amounts shall be withheld from the carrier or sponsor for payment into the in the All-Payer Health Care Fraud and Abuse Control Account established under section 9212 of the Health Security Act.

“(5) No action may be brought under this subsection more than 6 years after the date of the activity with respect to which the action is brought.”.

SEC. 9204. AMENDMENTS TO EXCLUSIONARY PROVISIONS IN FRAUD AND ABUSE PROGRAM.

(a) **MANDATORY EXCLUSION OF INDIVIDUAL CONVICTED OF CRIMINAL OFFENSE RELATED TO HEALTH CARE FRAUD.**—

(1) **IN GENERAL.**—Section 1128(a) of the Social Security Act (42 U.S.C. 1320a-7(a)) is amended by adding at the end the following new paragraph:

“(3) **FELONY CONVICTION RELATING TO FRAUD.**—Any individual or entity that has been convicted under Federal or State law, in connection with the delivery of a health care item or service on or after January 1, 1996, or with respect to any act or omission on or after such date in a program operated by or financed in whole or in part by any Federal, State, or local government agency,

of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.”.

(2) CONFORMING AMENDMENT.—Section 1128(b)(1) of such Act (42 U.S.C. 1320a-7(b)(1)) is amended—

(A) in the heading, by striking “CONVICTION” and inserting “MISDEMEANOR CONVICTION”; and

(B) by striking “criminal offense” and inserting “criminal offense consisting of a misdemeanor”.

(b) ESTABLISHMENT OF MINIMUM PERIOD OF EXCLUSION FOR CERTAIN INDIVIDUALS AND ENTITIES SUBJECT TO PERMISSIVE EXCLUSION FROM MEDICARE AND STATE HEALTH CARE PROGRAMS.—

(1) IN GENERAL.—Section 1128(c)(3) of such Act (42 U.S.C. 1320a-7(c)(3)) is amended by adding at the end the following new subparagraphs:

“(D) In the case of an exclusion of an individual or entity under paragraphs (1), (2), or (3) of subsection (b), the period of exclusion shall be a minimum of 3 years, unless the Secretary determines that an alternative period is appropriate because of aggravating or mitigating circumstances.

“(E) In the case of an exclusion of an individual or entity under paragraph (4) or (5) of subsection (b), the period of the exclusion shall not be less than the period during which the individual’s or entity’s license to provide health care is revoked, suspended, or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.

“(F) In the case of an exclusion of an individual or entity under subsection (b)(6)(B), the period of the exclusion shall be not less than 1 year.”.

(2) CONFORMING AMENDMENT.—Section 1128(c)(3)(A) of such Act (42 U.S.C. 1320a-7(c)(3)(A)) is amended by striking “subsection (b)(12)” and inserting “paragraph (1), (2), (3), (4), (6)(B), or (12) of subsection (b)”.

SEC. 9205. SANCTIONS AGAINST PRACTITIONERS AND PERSONS FOR FAILURE TO COMPLY WITH STATUTORY OBLIGATIONS RELATING TO QUALITY OF CARE.

(a) MINIMUM PERIOD OF EXCLUSION FOR PRACTITIONERS AND PERSONS FAILING TO MEET STATUTORY OBLIGATIONS.—

(1) IN GENERAL.—The second sentence of section 1156(b)(1) of the Social Security Act (42 U.S.C. 1320c-5(b)(1)) is amended by striking “may prescribe” and inserting “may prescribe, except that such period may not be less than one year”.

(2) CONFORMING AMENDMENT.—Section 1156(b)(2) of such Act (42 U.S.C. 1320c-5(b)(2)) is amended by striking “shall remain” and inserting “shall (subject to the minimum period specified in the second sentence of paragraph (1)) remain”.

(b) AMOUNT OF CIVIL MONEY PENALTY.—Section 1156(b)(3) of such Act (42 U.S.C. 1320c-5(b)(3)) is amended by striking “the actual or estimated cost” and inserting the following: “\$10,000 for each instance”.

(c) REPEAL OF “UNWILLING OR UNABLE” CONDITION FOR IMPOSITION OF SANCTION.—Section 1156(b)(1) of such Act (42 U.S.C. 1320c-5(b)(1)) is amended—

(1) in the second sentence, by striking “and determines” and all that follows through “such obligations,” and

(2) by striking the third sentence.

SEC. 9206. REVISIONS TO CRIMINAL PENALTIES.

(a) TREBLE DAMAGES FOR CRIMINAL SANCTIONS.—Section 1128B of the Social Security Act (42 U.S.C. 1320a-7b) is amended by adding at the end the following new subsection:

“(f) In addition to the fines that may be imposed under subsection (a) or (c) any individual found to have violated the provisions of any of such subsections may be subject to treble damages.”.

(b) IDENTIFICATION OF COMMUNITY SERVICE OPPORTUNITIES.—Section 1128B of such Act (42 U.S.C. 1320a-7b), as amended by subsection (a), is further amended by adding at the end the following new subsection:

“(g) The Secretary shall—

“(1) in consultation with State and local health care officials, identify opportunities for the satisfaction of community service obligations that a court may impose upon the conviction of an offense under this section, and

“(2) make information concerning such opportunities available to Federal and State law enforcement officers and State and local health care officials.”.

SEC. 9207. EFFECTIVE DATE.

The amendments made by this part shall take effect January 1, 1996.

PART 2—ESTABLISHMENT OF ALL-PAYER HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM

SEC. 9211. ALL-PAYER HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM.

(a) IN GENERAL.—Not later than January 1, 1996, the Secretary (acting through the Inspector General of the Department of Health and Human Services) and the Attorney General shall establish a program—

(1) to coordinate the functions of the Attorney General, the Secretary, and other organizations with respect to the prevention, detection, and control of health care fraud and abuse,

(2)(A) to conduct investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care services in the United States which are not subject to investigation, audit, evaluation, and inspection by the Inspector General of another executive department, and (B) to facilitate the conducting of such investigations, audits, evaluations, and inspections relating to the delivery of and payment for other health care services in the United States, and

(3) to facilitate the enforcement of this subtitle and other statutes applicable to health care fraud and abuse.

(b) COORDINATION WITH LAW ENFORCEMENT AGENCIES.—In carrying out the program under subsection (a), the Secretary and Attorney General shall consult with, and arrange for the sharing of data and resources with Federal, State and local law enforcement agencies, State Medicaid Fraud Control Units, and State agencies responsible for the licensing and certification of health care providers.

(c) COORDINATION WITH HEALTH PLANS.—In carrying out the program under subsection (a), the Secretary and Attorney General shall consult with, and arrange for the sharing of data with representatives of qualified health plans.

(d) AUTHORITIES OF ATTORNEY GENERAL AND INSPECTOR GENERAL.—In carrying out duties under subsection (a), the Attorney General and the Inspector General are authorized—

(1) to conduct, supervise, and coordinate audits, civil and criminal investigations, inspections, and evaluations relating to the program established under such subsection; and

(2) to have access (including on-line access as requested and available) to all records available to qualified health plans relating to the activities described in paragraph (1) (subject to restrictions based on the confidentiality of certain information under subtitle A of title X).

(e) FAILURE TO PROVIDE INFORMATION AS GROUNDS FOR PERMISSIVE EXCLUSION UNDER MEDICARE AND MEDICAID.—Section 1128(b)(9) of the Social Security Act (42 U.S.C. 1320a-7(b)(9)) is amended by striking the period at the end and inserting “, or provide any information requested by the Attorney General or the Inspector General of the Department of Health and Human Services to carry out the All-Payer Health Care Fraud and Abuse Control Program established under section 9211 of the Health Security Act.”;

(f) QUALIFIED IMMUNITY FOR PROVIDING INFORMATION.—The provisions of section 1157(a) of the Social Security Act (relating to limitation on liability) shall apply to a person providing information or communications to the Secretary or Attorney General in conjunction with their performance of duties under this section, in the same manner as such section applies to information provided to organizations with a contract under part B of title XI of such Act.

(g) AUTHORIZATIONS OF APPROPRIATIONS FOR INVESTIGATORS AND OTHER PERSONNEL.—In addition to any other amounts authorized to be appropriated to the Secretary and the Attorney General for health care anti-fraud and abuse activities for a fiscal year, there are authorized to be appropriated such additional amounts as may be necessary to enable the Secretary and the Attorney General to conduct investigations, audits, evaluations, and inspections of allegations of health care fraud and abuse and otherwise carry out the program established under subsection (a) in a fiscal year.

(h) USE OF POWERS UNDER INSPECTOR GENERAL ACT OF 1978.—In carrying out duties and responsibilities under the program established under subsection (a), the Inspector General is authorized to exercise all powers granted under the Inspector General Act of 1978 to the same manner and extent as provided in that Act.

(i) DEFINITION.—In this subtitle, the term “Inspector General” means the Inspector General of the Department of Health and Human Services.

SEC. 9212. ESTABLISHMENT OF ALL-PAYER HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.

(a) ESTABLISHMENT.—

(1) **IN GENERAL.**—There is hereby created on the books of the Treasury of the United States an account to be known as the “All-Payer Health Care Fraud and Abuse Control Account” (in this section referred to as the “Anti-Fraud Account”). The Anti-Fraud Account shall consist of such gifts and bequests as may be made as provided in paragraph (2) and such amounts as may be deposited in such Anti-Fraud Account as provided in section 9222(d)(2) and title XI of the Social Security Act. It shall also include the following:

(A) All criminal fines imposed in cases involving a Federal health care offense (as defined in subsection (d)).

(B) Penalties and damages imposed under the False Claims Act (31 U.S.C. 3729 et seq.), in cases involving claims related to the provision of health care items and services (other than funds awarded to a relator or for restitution).

(C) Administrative penalties and assessments imposed under titles XI, XVIII, and XIX of the Social Security Act and section 9222 (except as otherwise provided by law).

(D) Amounts resulting from the forfeiture of property by reason of a Federal health care offense.

(E) Amounts received from the payment of fees to the Secretary of Health and Human Services and the Attorney General under section 9232 by individuals and entities requesting advisory opinions under section 9231.

Any such funds received on or after the date of the enactment of this Act shall be deposited in the Anti-Fraud Account.

(2) **AUTHORIZATION TO ACCEPT GIFTS.**—The Anti-Fraud Account is authorized to accept on behalf of the United States money gifts and bequests made unconditionally to the Anti-Fraud Account, for the benefit of the Anti-Fraud Account or any activity financed through the Anti-Fraud Account.

(3) **ADMINISTRATION THROUGH BOARD OF TRUSTEES.**—The Anti-Fraud Account shall have a Board of Trustees consisting of the Secretary of Treasury, the Attorney General, the Secretary of Health and Human Services, the Inspector General, and a State Attorney General selected by the Inspector General. The Board of Trustees shall allocate and dispense funds in the Account and generally administer the operations of the Account.

(b) USE OF FUNDS.—

(1) **IN GENERAL.**—Amounts in the Anti-Fraud Account shall be available without appropriation and until expended as determined jointly by the Secretary and Attorney General in carrying out the All-Payer Health Care Fraud and Abuse Control Program established under section 9211 (including the administration of the Program), and may be used to cover costs incurred in operating the Program, including—

(A) costs of prosecuting health care matters (through criminal, civil and administrative proceedings);

(B) costs of investigations (including equipment, salaries, administratively uncontrollable work, travel, and training of law enforcement personnel);

(C) costs of financial and performance audits of health care programs and operations; and

(D) costs of inspections and other evaluations.

(2) **FUNDS USED TO SUPPLEMENT AGENCY APPROPRIATIONS.**—It is intended that disbursements made from the Anti-Fraud Account to any Federal agency be used to increase and not supplant the recipient agency’s appropriated operating budget.

(3) **USE OF FUNDS FOR EDUCATIONAL ACTIVITIES.**—Amounts in the Anti-Fraud Account may be used to carry out activities designed to educate providers of health care services about the provisions of this subtitle (and the provisions of law amended by this subtitle).

(4) **START-UP COSTS OF PROCESS FOR ISSUANCE OF ADVISORY OPINIONS.**—Amounts in the Anti-Fraud Account may be used to establish the process described in section 9231 for the issuance of advisory opinions by the Secretary of Health and Human Services and the Attorney General, but only during the first year for which the process is in operation.

(c) **ANNUAL REPORT.**—The Board of Trustees shall submit an annual report to Congress on the amount of revenue which is generated and disbursed by the Anti-Fraud Account in each fiscal year.

(d) **FEDERAL HEALTH CARE OFFENSE DEFINED.**—The term “Federal health care offense” means a violation of, or a criminal conspiracy to violate—

- (1) sections 226, 668, 1033, or 1347 of title 18, United States Code;
- (2) section 1128B of the Social Security Act;
- (3) sections 287, 371, 664, 666, 1001, 1027, 1341, 1343, or 1954 of title 18, United States Code, if the violation or conspiracy relates to health care fraud;
- (4) sections 501 or 511 of the Employee Retirement Income Security Act of 1974, if the violation or conspiracy relates to health care fraud; or
- (5) sections 301, 303(a)(2), or 303(b) or (e) of the Federal Food Drug and Cosmetic Act, if the violation or conspiracy relates to health care fraud.

PART 3—APPLICATION OF FRAUD AND ABUSE AUTHORITIES UNDER THE SOCIAL SECURITY ACT TO OTHER PAYERS

SEC. 9221. APPLICATION OF CIVIL MONEY PENALTIES TO ALL PAYERS.

(a) **ACTIONS SUBJECT TO PENALTY.**—Any person who is determined by the Secretary to have committed any of the following actions with respect to a qualified health plan shall be subject to a penalty in accordance with subsection (b):

(1) **ACTIONS SUBJECT TO PENALTY UNDER MEDICARE, MEDICAID, AND OTHER SOCIAL SECURITY HEALTH PROGRAMS.**—Any action that would subject the person to a penalty under paragraphs (1) through (9) of section 1128A(a) of the Social Security Act if the action was taken with respect to title V, XVIII, XIX, or XX of such Act.

(2) **TERMINATION OF ENROLLMENT.**—The termination of an individual’s enrollment (including the refusal to re-enroll an individual) in violation of title XXII of the Social Security Act (as added by title V).

(3) **DISCRIMINATING ON BASIS OF MEDICAL CONDITION.**—The engagement in any practice that would reasonably be expected to have the effect of denying or discouraging the initial or continued enrollment in a qualified health plan or medicare part C by individuals whose medical condition or history indicates a need for substantial future medical services.

(4) **INDUCING ENROLLMENT ON FALSE PRETENSES.**—The engagement in any practice to induce enrollment in a qualified health plan or medicare part C through representations to individuals which the person knows or should know are false or fraudulent.

(b) **PENALTIES DESCRIBED.**—

(1) **GENERAL RULE.**—Any person who the Secretary determines has committed an action described in paragraphs (2) through (4) of subsection (a) shall be subject to a civil monetary penalty in an amount not to exceed \$10,000 for each such determination.

(2) **ACTIONS SUBJECT TO PENALTIES UNDER SOCIAL SECURITY ACT.**—In the case of a person who the Secretary determines has committed an action described in paragraph (1) of subsection (a), the person shall be subject to the civil monetary penalty (together with any additional assessment) to which the person would be subject under section 1128A of the Social Security Act if the action on which the determination is based had been committed with respect to title V, XVIII, XIX, or XX of such Act.

(c) **APPLICABILITY OF PROCEDURES UNDER SOCIAL SECURITY ACT.**—The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to the imposition of a civil monetary penalty or assessment under this section in the same manner as such provisions apply with respect to the imposition of a penalty or assessment under section 1128A of such Act.

(d) **TREATMENT OF AMOUNTS RECOVERED.**—Any amounts recovered under this section shall be paid to the Secretary and disposed of as follows:

(1) Such portions of the amounts recovered as is determined to have been improperly paid from a qualified health plan for the delivery of or payment for health care items or services shall be repaid to such plan.

(2) The remainder of the amounts recovered shall be deposited in the All-Payer Health Care Fraud and Abuse Control Account established under section 9212.

(e) **NOTIFICATION OF LICENSING AUTHORITIES.**—Whenever the Secretary’s determination to impose a penalty or assessment under this section becomes final, the Secretary shall notify the appropriate State or local licensing agency or organization (including the agency specified in section 1864(a) and 1902(a)(33) of the Social Security Act).

ity Act) that such a penalty or assessment has become final and the reasons therefore.

SEC. 9222. APPLICATION OF CERTAIN CRIMINAL PENALTIES TO ALL PAYERS.

Any person who is determined by the Attorney General (in consultation with the Secretary) to have committed any action with respect to a qualified health plan that would subject the person to a penalty under subsection (a) or (b) of section 1128B of the Social Security Act if the action was taken with respect to title V, XVIII, XIX, or XX of such Act shall be subject to the penalty (together with any assessment) that would apply if the action was taken with respect to any such title.

SEC. 9223. CONSTRUCTION OF SOCIAL SECURITY ACT REFERENCES.

(a) **INCORPORATION OF OTHER AMENDMENTS.**—Any reference in this part to a provision of the Social Security Act shall be considered a reference to the provision as amended under part 1.

(b) **EFFECT OF SUBSEQUENT AMENDMENTS.**—Except as provided in subsection (a), any reference to a provision of the Social Security Act in this part shall be deemed to be a reference to such provision as in effect on the date of the enactment of this Act, and (except as Congress may otherwise provide) any amendments made to such provisions after such date shall not be taken into account in determining the applicability of such provisions to individuals and entities under this Act.

PART 4—ADVISORY OPINIONS ON KICKBACKS AND SELF-REFERRAL

SEC. 9231. ESTABLISHMENT OF PROCESS FOR ISSUANCE OF ADVISORY OPINIONS.

(a) **ESTABLISHMENT.**—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services (in consultation with the Attorney General) shall establish a process under which individuals and entities may submit a request to the Secretary for an advisory opinion regarding whether any conduct of the individual or entity—

(1) constitutes grounds for the imposition of a sanction under section 1128B(b) (relating to kickbacks, bribes, and rebates) of the Social Security Act or under part 3 through the application of such section; or

(2) would result in the denial of payment for a service furnished by the individual or entity, or the imposition of a civil money penalty, on the basis described in section 1877 of the Social Security Act or pursuant to section 9311.

(b) **DEADLINE FOR RESPONSE.**—The Secretary of Health and Human Services shall respond to a request for an advisory opinion submitted under subsection (a) not later than 90 days after receiving the request.

(c) **OPINIONS LIMITED TO QUESTIONS OF FACT.**—An advisory opinion issued under subsection (a) may only respond to the facts presented by the individual or entity requesting the advisory opinion.

(d) **ISSUANCE OF REGULATIONS.**—The Secretary may issue such regulations as the Secretary considers appropriate to carry out this part, including regulations concerning the process under which individuals and entities submit and the Secretary responds to requests for advisory opinions.

SEC. 9232. IMPOSITION OF FEES.

(a) **IN GENERAL.**—The Secretary of Health and Human Services and the Attorney General shall require an individual or entity requesting an advisory opinion under section 9231 to submit a fee.

(b) **AMOUNT.**—The amount of the fee required under subsection (a) shall be equal to the costs incurred by the Secretary and the Attorney General in responding to the request.

PART 5—PREEMPTION OF STATE CORPORATE PRACTICE LAWS

SEC. 9241. PREEMPTION OF STATE LAWS PROHIBITING CORPORATE PRACTICE OF MEDICINE.

No provision of State or local law shall apply that prohibits a corporation from practicing medicine.

Subtitle D—Physician Ownership and Referral

PART 1—REVISIONS TO LIMITATIONS ON PHYSICIAN SELF-REFERRALS

SEC. 9301. APPLICATION OF BAN ON SELF-REFERRALS TO CLAIMS SUBMITTED BY PHYSICIANS.

Section 1877(a)(1)(B) of the Social Security Act (42 U.S.C. 1395nn(a)(1)(B)) is amended to read as follows:

“(B) no physician or entity may present or cause to be presented a claim under this title or bill to any individual, third party payor, or other entity for designated health services furnished pursuant to a referral prohibited under subparagraph (A).”.

SEC. 9302. EXPANSION OF SELF-REFERRAL BAN TO ADDITIONAL SERVICES.

Section 1877(h)(6) of the Social Security Act (42 U.S.C. 1395nn(h)(6)) is amended—

- (1) in subparagraph (D), by striking “or other diagnostic”; and
- (2) by adding at the end the following new subparagraphs:

“(L) Home infusion drug therapy services (other than services consisting of the furnishing of infusion pumps).

“(M) Any other item or service not rendered by the physician personally or by a person under the physician’s direct supervision.”.

SEC. 9303. EXCEPTIONS FOR BOTH OWNERSHIP AND COMPENSATION ARRANGEMENTS.

(a) **REPEAL OF EXCEPTION FOR PHYSICIANS’ SERVICES.**—Section 1877(b) of the Social Security Act (42 U.S.C. 1395nn(b)) is amended by striking paragraph (1).

(b) **REVISION TO IN-OFFICE ANCILLARY SERVICES EXCEPTION.**—

(1) **IN GENERAL.**—Section 1877(b) of such Act (42 U.S.C. 1395nn(b)(1)), as amended by subsection (a), is amended by striking “Subsection (a)(1) shall not apply in the following cases” and all that follows through paragraph (2) and inserting the following:

“(1) **IN-OFFICE ANCILLARY SERVICES OF SOLE PRACTITIONERS.**—Subsection (a)(1) shall not apply in the case of designated health services—

“(A) that are furnished—

“(i) personally by the referring physician or personally by individuals who are directly supervised by the physician,

“(ii) in an office location in which the referring physician furnishes physicians’ services unrelated to the furnishing of designated health services, and

“(iii) using equipment that is wholly owned or leased exclusively by the referring physician; and

“(B) that are billed by the physician performing or supervising the services or by an entity that is wholly owned by such physician, if the ownership or investment interest in such services meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

“(2) **IN-OFFICE ANCILLARY SERVICES OF PHYSICIANS IN GROUP PRACTICE.**—Subject to subsection (h)(4)(C), subsection (a)(1) shall not apply in the case of designated health services—

“(A) that are furnished personally by the referring physician, personally by a physician who is a member of the same group practice as the referring physician, or personally by individuals who are directly supervised by any physician who is a member of such group practice;

“(B) that are furnished in a building in which a physician who is a member of the group practice furnishes physicians’ services unrelated to the furnishing of designated health services;

“(C) that are furnished using equipment that is owned or leased exclusively by the physician group; and

“(D) that are billed by the group practice of which the physician is a member under a billing number assigned to the group practice, or by an entity that is wholly owned by such group practice,

unless the Secretary determines other terms and conditions under which the provision of such services does not present a risk of program or patient abuse.

“(2) **DIRECT SUPERVISION.**—In this subsection, a physician shall be considered to directly supervise the furnishing of a service if the physician is present in the office suite where the service is furnished and is immediately available to

provide assistance and direction throughout the time the service is being performed (without regard to whether or not the person performing the service is an employee of the physician or the group practice).”.

(2) REQUIREMENTS FOR GROUP PRACTICE.—Section 1877(h)(4) of such Act (42 U.S.C. 1395nn(h)(4)) is amended by adding at the end the following new subparagraph:

“(C) REQUIREMENTS FOR GROUP PRACTICE.—For purposes of subsection (b)(2), a group practice meets the requirements of this subparagraph only if—

“(i) no member of the group is permitted to personally employ any individual to participate in the furnishing of services to patients of the group;

“(ii) no member of the group is permitted to enter separately on the member's own behalf into arrangements with any type of managed care entity (including health maintenance organizations and preferred provider organizations), third party payer, or other health benefit plan for the provision of services to patients of the group, except that nothing in this clause may be construed to prohibit the group from entering into an arrangement with a managed care entity that does not apply to services furnished by all the members of the group; and

“(iii) the group has a governing body or persons with responsibility for the conduct of the group practice, including making decisions relating to retention of all physician and nonphysician personnel, promulgating and enforcing personnel policies which apply to all employees of the group, developing salary, bonus, and benefits applicable to physicians and nonphysician personnel, and establishing fees for all services furnished by the group, except that nothing in this clause may be construed to prohibit the delegation of authority within a group practice or to require the personnel policies to be documented in writing.”.

(c) NEW EXCEPTION FOR CAPITATED PAYMENTS.—Section 1877(b) of such Act (42 U.S.C. 1395nn(b)), as amended by subsection (a), is amended—

(1) by redesignating paragraph (3) as paragraph (4); and

(2) by inserting after paragraph (2) the following new paragraph:

“(3) OTHER CAPITATED PAYMENTS.—Subsection (a)(1) shall not apply in the case of a designated health service, if the designated health service is included in the services for which a physician or physician group is paid only on a capitated basis by a health plan or insurer pursuant to a written arrangement between the plan or insurer and the physician or physician group in which the physician or physician group assumes financial risk for the furnishing of the service.”.

(d) NEW EXCEPTION FOR SHARED FACILITY SERVICES.—

(1) IN GENERAL.—Section 1877(b) of such Act (42 U.S.C. 1395nn(b)), as amended by subsections (a) and (c), is amended—

(A) by redesignating paragraph (4) as paragraph (3); and

(B) by inserting after paragraph (3) the following new paragraph:

“(4) SHARED FACILITY SERVICES.—

“(A) IN GENERAL.—Subsection (a)(1) shall not apply in the case of a designated health service consisting of a shared facility service of a shared facility—

“(i) that is furnished—

“(I) personally by the referring physician who is a shared facility physician or personally by an individual directly employed by such a physician,

“(II) by a shared facility in a building in which the referring physician furnishes substantially all of the services of the physician that are unrelated to the furnishing of shared facility services, and

“(III) to a patient of a shared facility physician; and

“(ii) that is billed by the referring physician.

“(B) SHARED FACILITY RELATED DEFINITIONS.—

“(i) SHARED FACILITY SERVICE.—The term ‘shared facility service’ means, with respect to a shared facility, a designated health service furnished by the facility to patients of shared facility physicians.

“(ii) SHARED FACILITY.—The term ‘shared facility’ means an entity that furnishes shared facility services under a shared facility arrangement.

“(iii) SHARED FACILITY PHYSICIAN.—The term ‘shared facility physician’ means, with respect to a shared facility, a physician who has a

financial relationship under a shared facility arrangement with the facility.

“(iv) SHARED FACILITY ARRANGEMENT.—The term ‘shared facility arrangement’ means, with respect to the provision of shared facility services in a building, a financial arrangement—

“(I) which is only between physicians who are providing services (unrelated to shared facility services) in the same building,

“(II) in which the overhead expenses of the facility are shared, in accordance with methods previously determined by the physicians in the arrangement, among the physicians in the arrangement, and

“(III) which, in the case of a corporation, is wholly owned and controlled by shared facility physicians.”.

SEC. 9304. EXCEPTIONS RELATED ONLY TO OWNERSHIP OR INVESTMENT.

(a) REVISION TO PUBLICLY TRADED SECURITIES EXCEPTION.—Section 1877(c)(1) of the Social Security Act (42 U.S.C. 1395nn(c)(1)) is amended by inserting “at the time acquired by the physician” after “which may be purchased on terms generally available to the public”.

(b) REVISION TO RURAL PROVIDER EXCEPTION.—Section 1877(d)(2) of such Act (42 U.S.C. 1395nn(d)(2)) is amended by striking “substantially all” and inserting “not less than 75 percent (as determined in accordance with regulations of the Secretary)”.

SEC. 9305. REPEAL OF EXCEPTION FOR REMUNERATION UNRELATED TO PROVISION OF DESIGNATED HEALTH SERVICES.

Section 1877(e) of the Social Security Act (42 U.S.C. 1395nn(e)) is amended—

(1) by striking paragraph (4); and

(2) by redesignating paragraphs (5), (6), (7), and (8) as paragraphs (4), (5), (6), and (7).

SEC. 9306. REFERRING PHYSICIANS.

Section 1877(h)(5)(C) of the Social Security Act (42 U.S.C. 1395nn(H)(5)(C)) is amended—

(1) by striking “and a request” and inserting “a request”;

(2) by inserting after “radiation therapy,” the following: “and a request by a nephrologist for items or services related to renal dialysis,”; and

(3) by striking “or radiation oncologist” and inserting “radiation oncologist, or nephrologist”.

SEC. 9307. MISCELLANEOUS AND TECHNICAL PROVISIONS.

(a) CLARIFICATION OF COVERAGE OF INDIRECTLY HELD FINANCIAL INTERESTS.—The last sentence of section 1877(a)(2) of the Social Security Act (42 U.S.C. 1395nn(a)(2)) is amended by striking “an interest in an entity that holds an ownership or investment interest in any entity providing the designated health service” and inserting the following: “an interest held indirectly through means such as (but not limited to) holding a legal or beneficial interest in another entity (such as a trust) that holds such investment interest”.

(b) CLARIFICATION OF EXCEPTION FOR PAYMENTS BY A PHYSICIAN.—Section 1877(e)(7) of such Act (42 U.S.C. 1395nn(e)(7)), as redesignated by section 9305, is amended to read as follows:

“(7) PAYMENTS BY A PHYSICIAN FOR ITEMS AND SERVICES.—Payments made by a physician to an individual or entity as compensation for items or services if the items or services are furnished at a price that is consistent with fair market value.”.

(c) REPORTING REQUIREMENTS.—Section 1877(f) of such Act (42 U.S.C. 1395nn) is amended—

(1) in the matter before paragraph (1), by inserting “, investment, and compensation” after “ownership”;

(2) in paragraph (2), by inserting “, or with a compensation arrangement (as described in subsection (a)(2)(B)),” after “investment interest (as described in subsection (a)(2)(A))”;

(3) in paragraph (2), by inserting “interest or who have such a compensation relationship with the entity” before the period at the end;

(4) in the fourth sentence, by striking “covered items and” and inserting “designated health”; and

(5) by striking the third and fifth sentences.

(d) **REVISION OF EFFECTIVE DATE EXCEPTION PROVISION.**—Section 13562(b)(2) of the Omnibus Budget Reconciliation Act of 1993 is amended by striking subparagraphs (A) and (B) and inserting the following:

“(A) the second sentence of subsection (a)(2), and subsections (b)(2)(B) and (d)(2), of section 1877 of the Social Security Act (as in effect on the day before the date of the enactment of this Act) shall apply instead of the corresponding provisions in section 1877 (as amended by this Act);

“(B) section 1877(b)(4) of the Social Security Act (as in effect on the day before the date of the enactment of this Act) shall apply;

“(C) the requirements of section 1877(c)(2) of the Social Security Act (as amended by this Act) shall not apply to any securities of a corporation that meets the requirements of section 1877(c)(2) of the Social Security Act (as in effect on the day before the date of the enactment of this Act);

“(D) section 1877(e)(3) of the Social Security Act (as amended by this Act) shall apply, except that it shall not apply to any arrangement that meets the requirements of subsection (e)(2) or subsection (e)(3) of section 1877 of the Social Security Act (as in effect on the day before the date of the enactment of this Act);

“(E) the requirements of clauses (iv) and (v) of section 1877(h)(4)(A), and of clause (i) of section 1877(h)(4)(B), of the Social Security Act (as amended by this Act) shall not apply; and

“(F) section 1877(h)(4)(B) of the Social Security Act (as in effect on the day before the date of the enactment of this Act) shall apply instead of section 1877(h)(4)(A)(ii) of such Act (as amended by this Act).”.

(e) **CLARIFICATION OF SANCTION AUTHORITY.**—Section 1877(g)(4) of such Act (42 U.S.C. 1395nn(g)(4)) is amended by striking “Any physician” and all that follows through “to such entity,” and inserting the following: “Any physician or other entity that enters into an arrangement or scheme (such as a cross-referral arrangement or an arrangement with multiple leases overlapping in time for the same or similar rental space or equipment) which the physician or entity knows or should know has a principal purpose of inducing referrals to another entity, which referrals, if made directly by the physician or entity to such other entity,”.

(f) **AUTHORIZATION FOR SECRETARY TO ISSUE REGULATIONS.**—Section 1877 of such Act (42 U.S.C. 1395nn) is amended by adding at the end the following new subsection:

“(i) **ADDITIONAL REQUIREMENTS.**—The Secretary is authorized to impose by regulation such other requirements as needed to protect against program or patient abuse with respect to any of the exceptions under this section.”.

SEC. 9308. EFFECTIVE DATE.

The amendments made by this part shall apply to referrals made on or after January 1, 1996, except that—

(1) the amendments made by section 9306(2) shall apply as if included in the enactment of the Omnibus Budget Reconciliation Act of 1990; and

(2) the amendments made by section 9307(d) shall apply as if included in the enactment of the Omnibus Budget Reconciliation Act of 1993.

PART 2—EXTENSION OF LIMITATIONS ON SELF-REFERRAL UNDER MEDICARE TO REFERRALS UNDER PRIVATE PLANS

SEC. 9311. LIMITATIONS ON PHYSICIAN SELF-REFERRAL UNDER PRIVATE PLANS.

The provisions of section 1877 of the Social Security Act, as amended by part 1, shall apply to items and services (and payments and claims for payment for such items and services) furnished under any qualified health plan in the same manner as such provisions apply to designated health services (and payments and claims for payment for such services) under title XVIII of the Social Security Act.

TITLE X—LONG-TERM CARE

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Subtitle A—Long-Term Care Program

SEC. 10001. ESTABLISHMENT OF LONG-TERM CARE PROGRAM FOR HOME AND COMMUNITY-BASED SERVICES.

(a) IN GENERAL.—The Social Security Act is amended by adding after the titles added by sections 3001, 5001, and 8001(a) the following new title:

"TITLE XXIV—LONG-TERM CARE PROGRAM FOR HOME AND COMMUNITY-BASED SERVICES

"SEC. 2401. ESTABLISHMENT OF LONG-TERM CARE PROGRAM FOR HOME AND COMMUNITY-BASED SERVICES.

"The Secretary shall establish a long-term care program under this title to provide home and community-based services for individuals with severe disabilities without regard to age or income through approved State plans.

"SEC. 2402. INDIVIDUALS WITH SEVERE DISABILITIES.

"(a) IN GENERAL.—In this title, the term 'individual with severe disabilities' means any individual within one or more of the following 4 categories of individuals:

"(1) INDIVIDUALS REQUIRING HELP WITH ACTIVITIES OF DAILY LIVING.—An individual of any age who—

"(A) requires hands-on or standby assistance, supervision, or cueing (as defined in regulations) to perform three or more activities of daily living (as defined in subsection (c)), and

"(B) is expected to require such assistance, supervision, or cueing over a period of at least 100 days.

"(2) INDIVIDUALS WITH SEVERE COGNITIVE OR MENTAL IMPAIRMENT.—An individual of any age—

"(A) whose score, on a standard mental status protocol (or protocols) appropriate for measuring the individual's particular condition specified by the Secretary, indicates either severe cognitive impairment or severe mental impairment, or both;

"(B) who—

"(i) requires hands-on or standby assistance, supervision, or cueing with one or more activities of daily living,

"(ii) requires hands-on or standby assistance, supervision, or cueing with at least such instrumental activity (or activities) of daily living related to cognitive or mental impairment as the Secretary specifies, or

"(iii) displays symptoms of one or more serious behavioral problems (that is on a list of such problems specified by the Secretary) which create a need for supervision to prevent harm to self or others; and

"(C) whose is expected to meet the requirements of subparagraphs (A) and (B) over a period of at least 100 days.

"(3) INDIVIDUALS WITH SEVERE OR PROFOUND MENTAL RETARDATION.—An individual of any age who has severe or profound mental retardation (as determined according to a protocol specified by the Secretary).

"(4) SEVERELY DISABLED CHILDREN.—An individual under 6 years of age who—

"(A) has a severe disability or chronic medical condition,

"(B) but for receiving home and community-based services would require institutionalization in a hospital, nursing facility, or intermediate care facility for the mentally retarded, and

"(C) is expected to have such disability or condition and require such services over a period of at least 100 days.

"(b) DETERMINATION OF ELIGIBILITY.—

"(1) IN GENERAL.—The determination of whether an individual is an individual with severe disabilities shall be made, by persons or entities (which may be local care coordination agencies) specified under the State plan (under section 2404), using a uniform protocol consisting of an initial screening and assessment specified by the Secretary. A State may collect additional information, at the time of obtaining information to make such determination, in order to provide for the assessment and plan described in section 2403(b) or for other purposes. Such determination shall be made without regard to the individual's income or (except in the case described in subsection (a)(4)) the individual's age.

"(2) INITIAL SCREENING PROCESS.—The plan shall provide a process for the initial screening of individuals who appear to have some reasonable likelihood of being an individual with severe disabilities.

"(3) PERIODIC REASSESSMENT.—The determination that an individual is an individual with severe disabilities shall be considered to be effective under the State plan for a period of not more than 12 months (or for such longer period in such cases as a significant change in an individual's condition that may affect such determination is unlikely). A reassessment shall be made if there is a significant change in an individual's condition that may affect such determination.

"(4) FAIR HEARING PROCESS.—The State shall establish a fair hearing process for appeals of such determinations.

"(c) ACTIVITY OF DAILY LIVING DEFINED.—In this title, the term 'activity of daily living' means any of the following: eating, toileting, dressing, bathing, and transferring.

"SEC. 2403. HOME AND COMMUNITY-BASED SERVICES.

"(a) SCOPE OF SERVICES.—

"(1) IN GENERAL.—In this title, the term 'home and community-based services' includes, subject to paragraph (2), the following:

"(A) Agency-administered and consumer-directed personal assistance services (as defined in paragraph (3)).

"(B) Case management.

"(C) Homemaker and chore assistance.

"(D) Home modifications.

"(E) Respite services.

"(F) Assistive devices.

"(G) Adult day services.

"(H) Habilitation and rehabilitation.

"(I) Supported employment.

"(J) Home health services.

"(X) Any other care or assistive services (approved by the Secretary) that a State determines will help individuals with severe disabilities to remain in their homes and communities.

"(2) EXCLUSIONS.—Such term does not include coverage of the following:

"(A) Room and board.

"(B) Services furnished in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other institutional setting specified by the Secretary.

"(C) Items and services to the extent coverage is provided for the individual under a qualified health plan (as defined in section 2 of the Health Security Act) or under title XVIII or part A of title XXIII.

"(3) PERSONAL ASSISTANCE SERVICES DEFINED.—

"(A) IN GENERAL.—In this subsection, the term 'personal assistance services' includes hands-on and standby assistance, supervision, and cueing with activities of daily living, whether agency-administered or consumer-directed (as defined in subparagraph (B)).

"(B) CONSUMER-DIRECTED; AGENCY-ADMINISTERED.—In this title:

"(i) The term 'consumer-directed' means, with reference to personal assistance services or the provider of such services, services that are provided by an individual who is selected and managed (and, at the individual's option, trained) by the individual receiving the services.

"(ii) The term 'agency-administered' means, with respect to such services, services that are not consumer-directed.

"(C) LIMITATION ON LICENSURE OR CERTIFICATION.—A State may not subject consumer-directed providers of personal assistance services to licensure, certification, or other requirements which the Secretary finds not to be necessary for the health and safety of individuals with severe disabilities.

"(b) COST SHARING.—

"(1) NO OR NOMINAL COST SHARING FOR POOREST.—No cost sharing (other than nominal cost sharing) may be imposed for individuals with income (as determined under paragraph (3)) less than 150 percent of the Federal poverty level (as defined in paragraph (4)) applicable to a family of the size involved.

"(2) SLIDING SCALE FOR REMAINDER.—Cost sharing in the form of coinsurance (based on the amount paid under this title for a service) shall be imposed—

"(A) at a rate of 10 percent for individuals with severe disabilities with income not less than 150 percent, and less than 200 percent, of the applicable Federal poverty level;

"(B) at a rate of 20 percent for such individuals with income not less than 200 percent, and less than 250 percent, of the applicable Federal poverty level; and

"(C) at a rate of 25 percent for such individuals with income equal to at least 250 percent of such Federal poverty level.

"(3) DETERMINATION OF INCOME FOR PURPOSES OF COST SHARING.—Each State, or an agency designated by the State, shall determine the income of an individual with severe disabilities for purposes of this subsection, in a manner specified by the Secretary.

"(4) FEDERAL POVERTY LEVEL DEFINED.—In this subsection, the term 'Federal poverty level' means, for a family for a year, the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved for the year.

"(c) SPECIFICATION OF SERVICES TO BE COVERED.—

"(1) IN GENERAL.—Each State shall specify, in its plan under section 2404—

"(A) the methods and standards used to select the types, and the amount, duration, and scope, of home and community-based services to be covered under the plan and to be available to each category of individuals with severe disabilities;

"(B) how the types, and the amount, duration, and scope of the services specified meet the needs of individuals within each of such categories;

"(C) the extent and manner in which such services would be allocated among individuals with severe disabilities and categories of such individuals;

"(D) the manner in which such services are coordinated with each other and with health and long-term care services available outside the plan for individuals with severe disabilities; and

"(E) the manner in which individuals with severe disabilities will be assisted in obtaining services from other programs for which they may qualify (including home health services under title XVIII or part A of title XXIII and home and community-based services under a State plan approved under title XIX).

"(2) FLEXIBILITY IN MEETING INDIVIDUAL NEEDS.—The services—

"(A) shall be specified in a manner that permits sufficient flexibility for providers to meet the needs of individuals with severe disabilities in a cost effective manner;

"(B) may be specified in a manner that takes into account the availability of informal care; and

"(C) subject to subsection (a)(2)(B), may be delivered in an individual's home, a range of community residential arrangements, or outside the home.

"SEC. 2404. ADMINISTRATION THROUGH STATE PLANS.

"(a) **IN GENERAL.**—As a condition for the payment of funds to a State under section 2405, the State must have a plan for home and community-based services for individuals with severe disabilities approved by the Secretary. The Secretary may not approve such a plan unless the Secretary determines that the plan meets the requirements of subsection (b).

"(b) **PLAN REQUIREMENTS.**—The requirements for a State plan are as follows:

"(1) **ELIGIBILITY PROCESS.**—The plan shall provide for a process to determine if individuals are individuals with severe disabilities in accordance with section 2402(b).

"(2) **SPECIFICATION OF SERVICES, COST SHARING, TYPES OF PROVIDERS, AND REQUIREMENTS FOR PARTICIPATION.**—The plan shall—

"(A) specify, in accordance with section 2403(c), the home and community-based services to be provided under this title to individuals with severe disabilities;

"(B) impose cost sharing with respect to covered services only in accordance with section 2403(b); and

"(C) specify—

"(i) the types of service providers eligible to participate in the program under the plan, and

"(ii) any requirements for participation applicable to each type of service provider.

"(3) **PROVISION OF SERVICES.**—

"(A) **ACCORDING TO PLAN OF CARE.**—

"(i) **IN GENERAL.**—The State plan shall provide for home and community-based services to an individual with disabilities only if such services are provided consistent with an individualized plan of care.

"(ii) **PLAN OF CARE.**—Such plan of care shall—

"(I) be based on an assessment of the individual's need for such services,

"(II) be developed in consultation with the individual and the individual's family, and

"(III) be periodically reviewed and updated, as appropriate.

"(iii) **CONSTRUCTION.**—Nothing in this subparagraph shall be construed as requiring a State (under the State plan or otherwise) to provide all the services specified in such a plan.

"(B) **CONSUMER CHOICE.**—To the extent possible, the choice of an individual with severe disabilities (and that individual's family) regarding which covered services to receive and the providers who will provide such services shall be followed.

"(4) **PAYMENTS FOR SERVICES.**—The plan provides for payment for services in accordance with the schedules and payment methodology specified in subsection (e).

"(5) **BUDGETING AND FISCAL MANAGEMENT.**—

"(A) **LIMITATION ON ADMINISTRATIVE EXPENDITURES.**—The plan shall contain assurances that not more than an amount or level (specified by the Secretary) of expenditures under the plan for all quarters in any fiscal year shall be for administrative costs.

"(B) **USE OF STATE FUNDS FOR MATCHING.**—The plan shall provide assurances that Federal funds will not be used to provide for the State share of expenditures under this title.

"(C) **BUDGET PRIORITY FOR CONTINUING CURRENT SERVICES FOR CURRENT RECIPIENTS.**—If, because of a shortage of funds, the plan cannot provide services for all individuals with severe disabilities, the State plan shall give priority to the provision of such services to individuals who are already being provided services under the plan.

"(6) **QUALITY ASSURANCE AND SAFEGUARDS.**—The State plan shall provide for quality assurance and safeguards for applicants and beneficiaries in accordance with subsection (f).

"(7) **GENERAL ADMINISTRATION.**—

"(A) **STATE AGENCY.**—The plan shall designate a State agency or agencies to manage and coordinate benefits under the plan, in accordance with specifications included in the plan.

"(B) **USE OF LOCAL CARE COORDINATION AGENCIES.**—A State may contract with or establish local care coordination agencies throughout the State to

assure the availability of home and community-based services to individuals with severe disabilities residing throughout the State.

“(C) COORDINATION.—The plan shall specify how the plan—

“(i) will be integrated with the State medicaid plan, titles V and XX of the Social Security Act, programs under the Older Americans Act of 1965, programs under the Developmental Disabilities Assistance and Bill of Rights Act, the Individuals with Disabilities Education Act, and any other Federal or State programs that provide services or assistance targeted to individuals with severe disabilities, and

“(ii) will be coordinated with health plans.

“(8) REPORTS AND INFORMATION TO SECRETARY; AUDITS.—The plan shall provide that the State will furnish to the Secretary—

“(A) such reports, and will cooperate with such audits, as the Secretary determines are needed concerning the State’s administration of its plan under this title, including the processing of claims under the plan, and

“(B) such data and information as the Secretary may require in order to carry out the Secretary’s responsibilities.

“(c) STANDARDS FOR PLAN APPROVAL.—

“(1) IN GENERAL.—The Secretary shall establish standards for the approval of State plans under this section.

“(2) EFFECTIVENESS.—The approval of such a plan shall take effect as of the first day of the first fiscal year beginning after the date of such approval (except that any approval made before October 1, 1999, shall be effective as of such date). In order to budget funds allotted under this title, the Secretary may establish a deadline for the submission of such a plan before the beginning of a fiscal year as a condition of its approval effective with that fiscal year.

“(d) MONITORING STATE PERFORMANCE.—

“(1) IN GENERAL.—The Secretary shall monitor the performance of States in carrying out plans under this section and shall, not less often than every two years, evaluate the performance of State agencies in carrying out their programmatic and fiscal responsibilities under this title.

“(2) PERFORMANCE MEASURES.—In evaluating such performance, the Secretary shall take into account at least the following:

“(A) The State’s ability to maintain plan expenditures within amounts for which Federal payments are available under section 2405.

“(B) The plan’s ability to maximize the provision of services within the State’s allocation.

“(C) The State’s success at finding alternative sources of funding to pay for services authorized under a care plan.

“(D) The plan’s ability to maintain individuals with severe disabilities outside institutional settings.

“(E) The State’s ability to implement the requirement that the plan is a secondary payor to medicaid under section 2405(f)(1).

“(e) REQUIREMENTS RELATING TO PAYMENT FOR SERVICES.—

“(1) IN GENERAL.—Subject to paragraph (2), payments for services under the State plan shall be made based on—

“(A) the prospective payment system developed under paragraph (3)(B), or

“(B) in the absence of such a system, the fee schedules developed under paragraph (3)(A), or

“(C) in the absence of such a system or schedules, payment rates or methodologies developed by the providers for payment rates that are reasonable and ensure adequate participation and access to covered services.

“(2) USE OF CASH PAYMENTS AND VOUCHERS.—

“(A) IN GENERAL.—A State plan may provide for the use of vouchers and cash payments directly to individuals with severe disabilities to pay for covered services.

“(B) DETERMINATION OF PAYMENT RATES.—The plan shall specify the methods and criteria to be used to set rates for such cash payments and vouchers.

“(C) USE OF INTERMEDIATE ENTITIES FOR CONSUMER-DIRECTED SERVICES.—With respect to consumer-directed services furnished to an individual with severe disabilities by a provider, the plan may provide that an entity, other than the individual or provider—

“(i) would inform the individual and the provider of rights and responsibilities under all Federal and other applicable labor and tax laws, and

"(ii) would act as the employer of the provider for purposes of assuming responsibility for effective billing and for payments for service tax withholding, unemployment compensation, and workers' compensation under such laws.

In such a case individuals with severe disabilities retain the right to select, hire, terminate, and direct the work of such a provider.

"(3) DEVELOPMENT OF FEE SCHEDULES AND PROSPECTIVE PAYMENT SYSTEM.—

"(A) IN GENERAL.—The Secretary shall develop fee schedules for payment for home and community-based services. Such schedules shall be—

"(i) based on the estimated cost of visits by discipline or service, and

"(ii) adjusted to take into account variations in area wage levels and such other factors as the Secretary deems appropriate.

"(B) DEVELOPMENT OF PROSPECTIVE SCHEDULE.—To the extent practicable, the Secretary shall develop a prospective payment system for payment for home and community-based services. Such a system shall adjust payment rates to take into account—

"(i) variations in area wage levels, and

"(ii) predictable differences in the cost and utilization of such services, based on degree of dependency in relation to activities of daily living and other case-mix severity indicators of resource needs.

To the extent possible, the unit of payment shall be established on a per-episode basis rather than per-visit basis.

"(4) EXTRA BILLING NOT PERMITTED.—The plan shall restrict payment under the plan for covered services to those providers that agree to accept the payment under the plan (at the rates established under this subsection) and any cost sharing permitted or provided for under the plan as payment in full for services furnished under the plan.

"(f) QUALITY ASSURANCE AND SAFEGUARDS.—

"(1) QUALITY ASSURANCE REQUIREMENTS.—In order to assure the health and safety of individuals with severe disabilities, the Secretary shall establish, by not later than July 1, 1999, quality assurance and certification requirements—

"(A) for providers to receive payments under a State plan for furnishing home and community-based services, and

"(B) for enforcement of such requirements under the plan.

"(2) SAFEGUARDS.—

"(A) CONFIDENTIALITY.—The State plan shall provide safeguards which restrict the use or disclosure of information concerning applicants and beneficiaries to purposes directly connected with the administration of the plan.

"(B) SAFEGUARDS AGAINST ABUSE.—The State plans shall provide safeguards against physical, emotional, or financial abuse or exploitation (specifically including appropriate safeguards in cases where payment for program benefits is made by cash payments or vouchers given directly to individuals with severe disabilities).

"(g) REGULATIONS.—The Secretary shall issue such regulations as may be appropriate to carry out this title.

"SEC. 2405. PAYMENTS TO STATES; MEDICAID MAINTENANCE OF EFFORT.

"(a) IN GENERAL.—The Secretary, in accordance with the Cash Management Improvement Act and from the Long-Term Care Trust Fund established under section 2406, shall authorize payment to each State with a plan approved under this title, for each fiscal year (beginning with fiscal year 2000), of an amount equal to the sum of the following:

"(1) 100 PERCENT MATCH FOR FIRST 20 PERCENT OF ALLOCATION.—100 percent of the amounts expended under the plan during the fiscal year, not to exceed 20 percent of the State allocation under subsection (b)(1) for the fiscal year.

"(2) $\frac{6}{7}$ MATCH BETWEEN 30 AND 100 PERCENT OF ALLOCATION.—Six dollars for each seven dollars expended under the plan, to the extent such expenditures exceed 30 percent of such State allocation and do not exceed 100 percent of such State allocation.

"(3) 100 MATCH FOR RESIDUAL FEDERAL FUNDS.—100 percent of any additional amounts expended under the plan, but not to exceed the State's share of the reallocation pool for the fiscal year (determined under subsection (b)(3)).

"(b) ALLOCATION TO STATES.—

"(1) ALLOCATION OF FEDERAL FUNDS.—The Secretary shall allocate all the national long-term care allocation amount (described in paragraph (2)) for each fiscal year among the States in accordance with a formula based on—

"(A) the number of individuals with severe disabilities in the State within each of the categories of such individuals, and

"(B) the average per capita spending amounts within each State within each of such categories for home and community-based services.

"(2) NATIONAL LONG-TERM CARE ALLOCATION AMOUNT.—For any fiscal year, the national long-term care allocation amount is 125 percent of the Federal funds available under section 2406 for the fiscal year.

"(3) STATE SHARE OF REALLOTMENT POOL.—

"(A) IN GENERAL.—For purposes of subsection (a)(3), the State's share of the reallotment pool for the fiscal year under this paragraph is equal to—

"(i) in the case of a State that is not a fully participating State (as defined in subparagraph (D)), 0, or

"(ii) in the case of a fully participating State, the State's share (as determined under subparagraph (B)) of the redistribution pool (as determined under subparagraph (C)) for the fiscal year.

"(B) STATE SHARE.—For purposes of subparagraph (A), a State's share is equal to the ratio of—

"(i) the State allocation under paragraph (1) for the fiscal year, to

"(ii) the sum of such allocations for all fully participating States for the fiscal year.

"(C) REDISTRIBUTION POOL.—For purposes of subparagraph (A), the redistribution pool for a fiscal year is equal to the amount by which the available Federal funds under section 2406 for the fiscal year exceeds the total payments made to States under paragraphs (1) and (2) of subsection (a) for the fiscal year.

"(D) FULLY PARTICIPATING STATE.—The term 'fully participating State' means, for a fiscal year, a State for which the State voluntary contribution is equal to (or exceeds) 20 percent of the State allocation under paragraph (1) for the fiscal year.

"(E) STATE VOLUNTARY CONTRIBUTION.—The term 'State voluntary contribution' means the payments made under the State plan, net of any Federal payments made under this section.

"(c) STATE ENTITLEMENT.—This title constitutes budget authority in advance of appropriations Acts, and represents the obligation of the Federal Government to provide for the payment to States of amounts described in subsection (a).

"(d) DISALLOWANCE OF CERTAIN EXCESSIVE ADMINISTRATIVE COSTS.—For purposes of subsection (a), administrative expenditures that are in excess of the amounts permitted under section 2404(b)(5)(A) shall not be treated as expenditures under the State plan.

"(e) PAYMENTS ON ESTIMATES WITH RETROSPECTIVE ADJUSTMENTS.—The method of computing and making payments under this section shall be as follows:

"(1) The Secretary shall, prior to the beginning of each quarter in a fiscal year, estimate the amount to be paid to the State under subsection (a) for such quarter, based on a report filed by the State containing its estimate of one-quarter of the total sum to be expended in such fiscal year, and such other information as the Secretary may find necessary.

"(2) The Secretary shall provide for payment of the amount so estimated, reduced or increased, as the case may be, by any sum (not previously adjusted under this section) by which the Secretary finds that the estimate of the amount to be paid the State for any prior period under this section was greater or less than the amount which should have been paid.

"(f) REDUCTION OF PAYMENTS AUTHORIZED FOR FAILURE TO MAINTAIN MEDICAID EFFORT.—

"(1) PAYER OF LAST RESORT.—The Secretary shall reduce the amount of payments otherwise made to a State under this section by the amount of any expenditures under this title for services to individuals otherwise entitled to benefits under the title XVIII, part A of title XXIII, a State plan approved under title XIX, or any qualified health plan (as defined in section 2 of the Health Security Act).

"(2) MEDICAID MAINTENANCE OF EFFORT.—

"(A) IN GENERAL.—The Secretary also may reduce the amount of payments otherwise made to a State in a fiscal year under this section by the amount by which—

"(i) the State medicaid expenditures for home and community-based services in the fiscal year (as determined under subparagraph (B)), is less than

"(ii) the maintenance of effort level for the State for the fiscal year (as determined under subparagraph (C)).

“(B) STATE MEDICAID EXPENDITURES.—For purposes of this paragraph, a State’s ‘medicaid expenditures for home and community-based services’ in a fiscal year is—

“(i) the gross amount expended on medical assistance under the State medicaid plan in the fiscal year for home and community-based services, including a reasonable allocation (determined by the Secretary) of administrative expenses attributable to the provision of such services, reduced by

“(ii) the amount of the Federal financial participation attributable to such assistance and expenses under the medicaid program.

“(C) MAINTENANCE-OF-EFFORT LEVEL.—For purposes of subparagraph (A)(ii), the ‘maintenance-of-effort level’ for a State for a fiscal year (beginning with fiscal year 2000) is equal to—

“(i) the State’s medicaid expenditures for home and community-based services (as determined under subparagraph (B)) for fiscal year 1994,

“(ii) increased by the total nominal growth in the gross domestic product between 1994 and 1998, and

“(iii) increased for each year after 1998 and before the year in which the fiscal year involved ends by national medicare growth factor established under section 8201(c) of the Health Security Act for the year.

“(3) CONSTRUCTION.—Nothing in this subsection shall be construed as requiring States to determine eligibility for medical assistance under the State medicaid plan on behalf of individuals receiving benefits under this title.

“SEC. 2406. FEDERAL FUNDING.

“(a) FISCAL YEARS 2000 THROUGH 2004.—For purposes of this title, the available Federal funds for all State plans under this title—

“(1) for fiscal year 2000 is \$3 billion;

“(2) for fiscal year 2001 is \$4 billion;

“(3) for fiscal year 2002 is \$6 billion;

“(4) for fiscal year 2003 is \$8 billion; and

“(5) for fiscal year 2004 is \$10 billion.

“(b) SUBSEQUENT FISCAL YEARS.—For purposes of this title, the available Federal funds for State plans under this title for each fiscal year after fiscal year 2004 is the total available Federal funds under this section for the preceding fiscal year increased by the national medicare growth factor established under section 8201(c) of the Health Security Act for the year in which such preceding fiscal year ends.

(b) DEFINITION OF STATE.—Section 1101(a)(1) of the Social Security Act (42 U.S.C. 1301(a)(1)), as amended by section 8001(b)(4) of this Act, is amended by striking “or XXIII” and inserting “, title XXIII, or title XIV”.

Subtitle B—Federal Standards for Private Long-Term Care Insurance Policies

SEC. 10101. ESTABLISHMENT OF FEDERAL STANDARDS FOR PRIVATE LONG-TERM CARE INSURANCE POLICIES.

(a) IN GENERAL.—The Social Security Act is amended by adding after the titles added by sections 3001, 5001, 8001(a), and 10001(a) the following new title:

“TITLE XXV—FEDERAL STANDARDS FOR PRIVATE LONG-TERM CARE INSURANCE POLICIES

“PART A—ESTABLISHMENT AND ENFORCEMENT

“SEC. 2501. ESTABLISHMENT OF STANDARDS.

“(a) IN GENERAL.—The Secretary shall promulgate regulations as necessary to implement the provisions of this title.

“(b) DEADLINE FOR PUBLICATION OF REGULATIONS.—Regulations required to carry out this title shall first be published by not later than July 1, 1995.

“(c) CONSULTATION WITH NAIC.—In promulgating regulations under this title, the Secretary shall consult with the National Association of Insurance Commissioners (in this title referred to as the ‘NAIC’).

“(d) PREEMPTION OF STATE LAW.—No State law or regulation shall be enforced that is inconsistent with the standards promulgated under this title.

"SEC. 2502. ENFORCEMENT OF FEDERAL STANDARDS BY STATES.

"(a) **STATE ENFORCEMENT.**—No long-term care insurance policy (as defined in section 1141) may be issued, sold, or offered for sale in a State which has a regulatory program approved under section 2503 unless the policy has been approved under such program.

"(b) **FEDERAL BACKUP AUTHORITY.**—No long-term care insurance policy may be issued, sold, or offered for sale in a State which does not have a regulatory program approved under section 2503 unless the policy has been certified by the Secretary (in accordance with such procedures as the Secretary establishes) as meeting the Federal standards established under this title.

"(c) **TREATMENT OF ADVERTISING.**—For purposes of this section, the advertising or soliciting with respect to a policy, directly or indirectly, shall be deemed the offering for sale of the policy.

"(d) **SANCTIONS.**—Any person who issues or renews a policy, on or after the date specified in subsection (e), in violation of subsection (a) or (b) is subject to a civil money penalty of not to exceed \$10,000 for each such violation. The provisions of section 1128A of the Social Security Act (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under this subsection in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

"(e) **DEADLINE FOR APPLICATION OF STANDARDS.**—

"(1) **IN GENERAL.**—Subject to paragraph (2), the date specified in this subsection for a State is—

"(A) the date the State establishes a regulatory program under section 2503, or

"(B) January 1, 1997,
whichever is earlier.

"(2) **STATE REQUIREING LEGISLATION.**—In the case of a State which the Secretary identifies as—

"(A) requiring State legislation (other than legislation appropriating funds) in order to establish a regulatory program under section 2503, but

"(B) having a legislature which is not scheduled to meet in 1996 in a legislative session in which such legislation may be considered,
the date specified in this subsection is January 1, 1998, or, if earlier, the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1996. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

"SEC. 2503. REQUIREMENTS FOR STATE ENFORCEMENT PROGRAMS.

"(a) **IN GENERAL.**—The Secretary shall establish a process for the approval of State programs that enforce the Federal standards established under this title. The Secretary may not approve such a program unless it meets the requirements of this section.

"(b) **GENERAL REQUIREMENT.**—In order to be approved, a State program must include such laws and procedures as may be necessary to ensure the compliance of long-term care insurance policies sold in the State, and insurers offering such policies and their agents, with the Federal requirements established under this title.

"(c) **SPECIFIC ACTIVITIES UNDER STATE PROGRAM.**—In order to be approved, a State program shall provide for the following procedures and activities:

"(1) **MONITORING OF INSURERS AND POLICIES.**—Procedures for ongoing monitoring of the compliance of insurers doing business in the State, and of long-term care insurance policies sold in the State, with requirements under this title, including at least the following:

"(A) **POLICY REVIEW AND CERTIFICATION.**—A program for review and certification (and annual recertification) of each such policy sold in the State.

"(B) **REPORTING BY INSURERS.**—Requirements of annual reporting by insurers selling or servicing long-term care insurance policies in the State, in such form and containing such information as the State may require to determine whether the insurer (and policies) are in compliance with requirements under this title.

"(C) **DATA COLLECTION.**—Procedures for collection, from insurers, service providers, insured individuals, and others, of information required by the State for purposes of carrying out its responsibilities under this title (including authority to compel compliance of insurers with requests for such information).

"(D) **MARKETING OVERSIGHT.**—Procedures for monitoring (through sampling or other appropriate procedures) the sales practices of insurers and agents, including review of marketing literature.

"(2) **CONSUMER COMPLAINTS AND DISPUTE RESOLUTION.**—Administrative procedures for the investigation and resolution of complaints by consumers, and disputes between consumers and insurers, with respect to long-term care insurance, including procedures for the filing, investigation, and adjudication of consumer complaints with respect to the compliance of insurers and policies with requirements under this title, or other requirements under State law.

"(c) **REQUIRED STATE ENFORCEMENT AUTHORITIES.**—In order for a State program to be approved, the program shall ensure that the State insurance commissioner (or other appropriate official or agency) has the following authority with respect to long-term care insurers and policies:

"(1) **PROHIBITION OF SALE.**—Authority to prohibit the sale, or offering for sale, of any long-term care insurance policy that fails to comply with all applicable requirements under this title.

"(2) **PLANS OF CORRECTION.**—Authority, in cases where the business practices of an insurer are determined not to comply with requirements under this title, to require the insurer to develop, submit for State approval, and implement a plan of correction which must be fulfilled within the shortest period possible (not to exceed a year) as a condition of continuing to do business in the State.

"(3) **CORRECTIVE ACTION ORDERS.**—Authority, in cases where an insurer is determined to have failed to comply with requirements of this title, or with the terms of a policy, with respect to a consumer or insured individual, to direct the insurer (subject to appropriate due process) to eliminate such noncompliance within 30 days.

"(4) **OTHER AUTHORITIES.**—Such other authorities as the State finds necessary or appropriate to enforce requirements under this title.

"(d) **RECORDS, REPORTS, AND AUDITS.**—As a condition of approval of a State program under this section, a State must agree to maintain such records, make such reports (including expenditure reports), and cooperate with such audits, as the Secretary finds necessary to determine the compliance of such State program (and insurers and policies regulated under such program) with the requirements of this section.

"(e) **SECRETARIAL RESPONSIBILITIES.**—

"(1) **APPROVAL OF STATE PROGRAMS.**—The Secretary is responsible for reviewing and approving State programs under this section.

"(2) **PERIODIC REVIEW.**—The Secretary shall periodically review State programs approved under this section to determine whether they continue to comply with the requirements for such approval.

"(3) **NOTICE OF DETERMINATION OF NONCOMPLIANCE.**—The Secretary shall promptly notify the State of a determination that a State program fails to comply with the requirements of this section, specifying the requirement or requirements not met and the elements of the State program requiring correction.

"(4) **OPPORTUNITY FOR CORRECTION.**—

"(A) **IN GENERAL.**—The Secretary shall afford a State notified of noncompliance pursuant to paragraph (3) a reasonable opportunity to eliminate such noncompliance.

"(B) **CORRECTION PLANS.**—In a case where substantial corrections are needed to eliminate noncompliance of a State program, the Secretary may—

"(i) permit the State a reasonable time after the date of the notice pursuant to paragraph (3) to develop and obtain the Secretary's approval of a correction plan, and

"(ii) permit the State a reasonable time after the date of approval of such plan to eliminate the noncompliance.

"(5) **WITHDRAWAL OF PROGRAM APPROVAL.**—In the case of a State that fails to eliminate noncompliance with requirements under this section by the date specified by the Secretary pursuant to paragraph (4), the Secretary shall withdraw the approval of the State program under this section.

"PART B—FEDERAL STANDARDS

"SEC. 2521. REQUIREMENTS TO FACILITATE UNDERSTANDING AND COMPARISON OF BENEFITS.

"(a) **IN GENERAL.**—The Secretary, in consultation with the NAIC, shall promulgate regulations designed to standardize formats and terminology used in long-term care insurance policies, to require insurers to provide to customers and beneficiaries information on the range of public and private long-term care coverage available,

and to establish such other requirements as may be appropriate to promote consumer understanding and facilitate comparison of benefits, which shall include at a minimum the requirements specified in this section.

“(b) **UNIFORM TERMS, DEFINITIONS, AND FORMATS.**—Insurers shall be required to use, in long-term care insurance policies, uniform terminology, definitions of terms, and formats, in accordance with regulations promulgated by the Secretary.

“(c) **STANDARD OUTLINE OF COVERAGE.**—

“(1) **IN GENERAL.**—Insurers shall be required to develop for each long-term care insurance policy offered or sold, to include as a part of each such policy, and to make available to each potential purchaser and furnish to each insured individual and policyholder, an outline of coverage under such policy that—

“(A) includes the elements specified in paragraph (2),

“(B) is in a uniform format,

“(C) accurately and clearly reflects the contents of the policy, and

“(D) is updated periodically on such timetable as may be required by the Secretary (or more frequently as necessary to reflect significant changes in outlined information).

“(2) **CONTENTS OF OUTLINE.**—The outline of coverage for each long-term care insurance policy shall include at least the following:

“(A) **BENEFITS.**—A description of—

“(i) the principal benefits covered, including the extent of—

“(I) benefits for services furnished in residential care facilities, and

“(II) other benefits,

“(ii) the principal exclusions from and limitations on coverage,

“(iii) the terms and conditions, if any, upon which the insured individual may obtain upgraded benefits, and

“(iv) the threshold conditions for entitlement to receive benefits.

“(B) **CONTINUATION, RENEWAL, AND CONVERSION.**—A statement of the terms under which a policy may be—

“(i) returned (and premium refunded) during an initial examination period,

“(ii) continued in force or renewed,

“(iii) converted to an individual policy (in the case of coverage under a group policy),

“(C) **CANCELLATION.**—A statement of the circumstances in which a policy may be terminated, and the refund or nonforfeitures benefits (if any) applicable in each such circumstance, including—

“(i) death of the insured individual,

“(ii) nonpayment of premiums,

“(iii) election by the insured individual not to renew,

“(iv) any other circumstance.

“(D) **PREMIUM.**—A statement of—

“(i) the total annual premium, and the portion of such premium attributable to each covered benefit,

“(ii) any reservation by the insurer of a right to change premiums,

“(iii) any limit on annual premium increases,

“(iv) any expected premium increases associated with automatic or optional benefit increases (including inflation protection), and

“(v) any circumstances under which payment of premium is waived.

“(E) **DECLARATION CONCERNING SUMMARY.**—A statement, in bold face type on the face of the document in language understandable to the average individual, that the outline of coverage is a summary only, not a contract of insurance, and that the policy contains the contractual provisions that govern.

“(F) **COST/VALUE COMPARISON.**—

“(i) Information on average costs (and variation in such costs) for nursing facility care (and such other care as the Secretary may specify) in the United States, information on the value of benefits relative to such costs, and a statement that this national average varies by geographic region.

“(ii) A comparison of benefits, over a period of at least 20 years, for policies with and without inflation protection.

“(iii) A declaration as to whether the amount of benefits will increase over time, and, if so, a statement of the type and amount of, any limitations on, and any premium increases for, such benefit increases.

“(G) **OTHER.**—Such other information as the Secretary may require.

"(3) PUBLICATION OF INFORMATION.—For purposes of carrying out paragraph (2)(F)(i), the Secretary shall publish annually the national average costs of nursing facility care, home health care services, and other long-term care services as may be deemed appropriate by the Secretary.

"(d) REPORTING TO STATE INSURANCE COMMISSIONER.—Each insurer shall be required to report at least annually, to the State insurance commissioner of each State in which any long-term care insurance policy of the insurer is sold, such information, in such format, as the Secretary may specify with respect to each such policy, including—

- "(1) the standard outline of coverage required pursuant to subsection (c);[§]
- "(2) lapse rates and replacement rates for such policies;
- "(3) the ratio of premiums collected to benefits paid;
- "(4) reserves;
- "(5) written materials used in sale or promotion of such policy; and
- "(6) any other information the Secretary may require.

"SEC. 2522. REQUIREMENTS RELATING TO COVERAGE.

"(a) IN GENERAL.—The Secretary, after consultation with NAIC, shall promulgate regulations establishing requirements with respect to the terms of and benefits under long-term care insurance policies, which shall include at a minimum the requirements specified in this section.

"(b) LIMITATIONS ON PREEXISTING CONDITION EXCLUSIONS.—

"(1) INITIAL POLICIES.—A long-term care insurance policy may not exclude or limit coverage for any service or benefit, the need for which is the result of a medical condition or disability because an insured individual received medical treatment for, or was diagnosed as having, such condition before the issuance of the policy, unless—

"(A) the insurer, prior to issuance of the policy, determines and documents (with evidence including written evidence that such condition has been treated or diagnosed by a qualified health care professional) that the insured individual had such condition during the 6-month period (or such longer period as the Secretary may specify) ending on the effective date of the policy; and

"(B) the need or such service or benefit begins within 6 months (or such longer period as the Secretary may specify) following the effective date of the policy.

"(2) REPLACEMENT POLICIES.—Solely for purposes of the requirements of paragraph (1), with respect to an insured individual, the effective date of a long-term care insurance policy issued to replace a previous policy, with respect to benefits which are the same as or substantially equivalent to benefits under such previous policy, shall be considered to be the effective date of such previous policy with respect to such individual.

"(c) LIMITING CONDITIONS ON BENEFITS.—

"(i) IN GENERAL.—A long-term care insurance policy may not—

"(A) condition eligibility for benefits for a type of service on the need for or receipt of any other type of service (such as prior hospitalization or institutionalization, or a higher level of care than the care for which benefits are covered);

"(B) condition eligibility for any benefit (where the need for such benefit has been established by an independent assessment of impairment) on any particular medical diagnosis (including any acute condition) or on one of a group of diagnoses;

"(C) condition eligibility for benefits furnished by licensed or certified providers on compliance by such providers with conditions not required under Federal or State law; or

"(D) condition coverage of any service on provision of such service by a provider, or in a setting, providing a higher level of care than that required by an insured individual.

"(2) HOME CARE OR COMMUNITY-BASED SERVICES.—A long-term care insurance policy that provides benefits for any home care or community-based services provided in a setting other than a residential care facility—

"(A) may not limit such benefits to services provided by registered nurses or licensed practical nurses;

"(B) may not limit such benefits to services furnished by persons or entities participating in programs under titles XVIII and XIX of the Social Security Act; and

"(C) must provide, at a minimum, benefits for personal assistance with activities of daily living, home health care, adult day care, and respite care.

"(3) NURSING FACILITY SERVICES.—A long-term care insurance policy that provides benefits for any nursing facility services—

"(A) must provide benefits for such services provided by all types of nursing facilities licensed by the State, and

"(B) may provide benefits for care in other residential facilities.

"(4) PROHIBITION ON DISCRIMINATION BY DIAGNOSIS.—A long-term care insurance policy may not provide for treatment of—

"(A) Alzheimer's disease or any other progressive degenerative dementia of an organic origin,

"(B) any organic or inorganic mental illness,

"(C) mental retardation or any other cognitive or mental impairment, or

"(D) HIV infection or AIDS,

different from the treatment of any other medical condition for purposes of determining whether threshold conditions for the receipt of benefits have been met, or the amount of benefits under the policy.

"SEC. 2523. INFLATION PROTECTION.

"(a) IN GENERAL.—The Secretary, after consultation with NAIC, shall promulgate regulations establishing requirements with respect to inflation protection, which shall include at a minimum the requirements specified in this section.

"(b) REQUIREMENT TO OFFER.—An insurer offering for sale any long-term care insurance policy shall be required to afford the purchaser the option to obtain coverage under such policy (upon payment of increased premiums) of annual increases in benefits at rates in accordance with subsection (c).

"(c) RATE INCREASE IN BENEFITS.—For purposes of subsection (b), the benefits under a policy for each year shall be increased by a percentage of the full value of benefits under the policy for the previous year, which shall be not less than 5 percent of such value (or such other rate of increase as may be determined by the Secretary to be adequate to offset increases in the costs of long-term care services for which coverage is provided under the policy).

"(d) REQUIREMENT OF WRITTEN REJECTION.—Inflation protection in accordance with subsection (b) may be excluded from the coverage under a policy only if the insured individual (or, if different, the person responsible for payment of premiums) has rejected in writing the option to obtain such coverage.

"SEC. 2524. NONFORFEITURE BENEFITS.

"(a) IN GENERAL.—The Secretary, after consultation with NAIC, shall promulgate regulations establishing requirements with respect to nonforfeiture benefits, which shall include at a minimum the requirements specified in this section.

"(b) REQUIREMENT.—Each long-term care insurance policy that lapses for any reason (including nonpayment of premiums, cancellation, or failure to renew, but excluding lapses due to death) after remaining in effect beyond a specified minimum period shall provide for appropriate nonforfeiture benefits.

"(c) NONFORFEITURE BENEFITS.—The standards established under this section shall require that the amount or percentage of nonforfeiture benefits shall increase proportionally with the amount of premiums paid by a policyholder.

"SEC. 2525. REQUIREMENTS RELATING TO SALES PRACTICES.

"(a) IN GENERAL.—The Secretary, in consultation with the NAIC, shall promulgate regulations establishing requirements applicable to the sale or offering for sale of long-term care insurance policies, which shall include at a minimum the requirements specified in this section.

"(b) APPLICATIONS.—Any insurer that offers any long-term care insurance policy (including any group policy) shall be required to meet such requirements with respect to the content, format, and use of application forms for long-term care insurance as the Secretary may require by regulation.

"(c) AGENT TRAINING AND CERTIFICATION.—An insurer may not sell or offer for sale a long-term care insurance policy through an agent who does not comply with minimum standards with respect to training and certification established by the Secretary.

"(d) PROHIBITED SALES PRACTICES.—The following practices by insurers shall be prohibited with respect to the sale or offer for sale of long-term care insurance policies:

"(1) FALSE AND MISLEADING REPRESENTATIONS.—Making any statement or representation—

"(A) which the insurer knows or should know is false or misleading (including the inaccurate, incomplete, or misleading comparison of long-term care insurance policies or insurers), and

“(B) which is intended, or would be likely, to induce any person to purchase, retain, terminate, forfeit, permit to lapse, pledge, assign, borrow against, convert, or effect a change with respect to, any long-term care insurance policy.

“(2) **INACCURATE COMPLETION OF MEDICAL HISTORY.**—Making or causing to be made (by any means including failure to inquire about or to record information relating to preexisting conditions) statements or omissions, in records detailing the medical history of an applicant for insurance, which the insurer knows or should know render such records false, incomplete, or misleading in any way material to such applicant's eligibility for or coverage under a long-term care insurance policy.

“(3) **UNDUE PRESSURE.**—Employing force, fright, threat, or other undue pressure, whether explicit or implicit, which is intended, or would be likely, to induce the purchase of a long-term care insurance policy.

“(4) **COLD LEAD ADVERTISING.**—Using, directly or indirectly, any method of contacting consumers (including any method designed to induce consumers to contact the insurer or agent) for the purpose of inducing the purchase of long-term care insurance (regardless of whether such purpose is the sole or primary purpose of the contact) without conspicuously disclosing such purpose.

“(e) **PROHIBITION ON SALE OF DUPLICATE BENEFITS.**—An insurer or agent may not sell or issue to an individual a long-term care insurance policy that the insurer or agent knows or should know provides for coverage that duplicates coverage already provided in another long-term care insurance policy held by such individual, unless—

“(1) the policy is intended to replace such other policy, or

“(2) the benefits under the new policy are fully payable directly to or on behalf of the individual without regard to other long-term care coverage of the individual).

“SEC. 2526. CONTINUATION, RENEWAL, REPLACEMENT, CONVERSION, AND CANCELLATION OF POLICIES.

“(a) **IN GENERAL.**—The Secretary, in consultation with NAIC, shall promulgate regulations establishing requirements applicable to the renewal, replacement, conversion, and cancellation of long-term care insurance policies, which shall include at a minimum the requirements specified in this section.

“(b) **INSURED'S RIGHT TO CANCEL DURING EXAMINATION PERIOD.**—Each individual insured (or, if different, each individual liable for payment of premiums) under a long-term care insurance policy shall have the unconditional right to return the policy within 30 days after the date of its issuance and delivery, and to obtain a full refund of any premium paid.

“(c) **INSURER'S RIGHT TO CANCEL (OR DENY BENEFITS) BASED ON FRAUD OR NONDISCLOSURE.**—An insurer shall have the right to cancel a long-term care insurance policy, or to refuse to pay a claim for benefits, based on evidence that the insured falsely represented or failed to disclose information material to the determination of eligibility to purchase such insurance, but only if—

“(1) the insurer presents written documentation, developed at the time the insured applied for such insurance, of the insurer's request for the information thus withheld or misrepresented, and the insured individual's response to such request;

“(2) the insurer presents medical records or other evidence showing that the insured individual knew or should have known that such response was false, incomplete, or misleading;

“(3) notice of cancellation is furnished to the insured individual before the date 3 years after the effective date of the policy (or such earlier date as the Secretary may specify in regulations); and

“(4) the insured individual is afforded the opportunity to review and refute the evidence presented by the insurer pursuant to paragraphs (1) and (2).

“(d) **INSURER'S RIGHT TO CANCEL FOR NONPAYMENT OF PREMIUMS.**—

“(1) **IN GENERAL.**—Insurers shall have the right to cancel long-term care insurance policies for nonpayment of premiums, subject to the provisions of this subsection and subsection (e) (relating to nonforfeiture).

“(2) **NOTICE AND ACKNOWLEDGEMENT.**—

“(A) **IN GENERAL.**—The insurer may not cancel coverage of an insured individual until—

“(i) the insurer, not earlier than the date when such payment is 30 days past due, has given written notice to the insured individual (by registered letter or the equivalent) of such intent, and

“(ii) 30 days have elapsed since the insurer obtained written acknowledgment of receipt of such notice from the insured individual (or the designated representative, at the insured individual’s option or in the case of an insured individual determined to be incapacitated in accordance with paragraph (4)).

“(B) ADDITIONAL REQUIREMENT FOR GROUP POLICIES.—In the case of a group long-term care insurance policy, the notice and acknowledgement requirements of subparagraph (A) apply with respect to the policyholder and to each insured individual.

“(3) REINSTATEMENT OF COVERAGE OF INCAPACITATED INDIVIDUALS.—In any case where the coverage of an individual under a long-term care insurance policy has been canceled pursuant to paragraph (2), the insurer shall be required to reinstate full coverage of such individual under such policy, retroactive to the effective date of cancellation, if the insurer receives from such individual (or the designated representative of such individual), within 5 months after such date—

“(A) evidence of a determination of such individual’s incapacitation in accordance with paragraph (4) (whether made before or after such date), and

“(B) payment of all premiums due and past due, and all charges for late payment.

“(4) DETERMINATION OF INCAPACITATION.—For purposes of this subsection, the term ‘determination of incapacitation’ means a determination by a qualified health professional (in accordance with such requirements as the Secretary may specify), that an insured individual has suffered a cognitive impairment or loss of functional capacity which could reasonably be expected to render the individual permanently or temporarily unable to deal with business or financial matters. The standard used to make such determination shall not be more stringent than the threshold conditions for the receipt of covered benefits.

“(5) DESIGNATION OF REPRESENTATIVE.—The insurer shall be required—

“(A) to offer the insured individual, at the time of sale or issuance of a long-term care insurance policy—

“(i) the right to designate a representative for purposes of communication with the insurer concerning premium payments in the event the insured individual cannot be located or is incapacitated, or

“(ii) the right to complete a signed and dated statement declining to designate a representative, and

“(B) to seek from the insured individual, at the time of each premium payment (but in no event less often than once in each 12-month period) reconfirmation or revision of such designation or declination.

“(e) CONTINUATION, RENEWAL, REPLACEMENT, AND CONVERSION OF POLICIES.—

“(1) IN GENERAL.—Insurers shall not be permitted to cancel, or refuse to renew (or replace with a substantial equivalent), any long-term care insurance policy for any reason other than for fraud or material misrepresentation (as provided in subsection (c)) or for nonpayment of premium (as provided in subsection (d)).

“(2) DURATION AND RENEWAL OF POLICIES.—Each long-term care insurance policy shall contain a provision that clearly states—

“(A) the duration of the policy,

“(B) the right of the insured individual (or policyholder) to renewal (or to replacement with a substantial equivalent),

“(C) the date by which, and the manner in which, the option to renew must be exercised, and

“(D) any applicable restrictions or limitations (which may not be inconsistent with the requirements of this title).

“(3) REPLACEMENT OF POLICIES.—

“(A) IN GENERAL.—Except as provided in subparagraph (B), an insurer shall not be permitted to sell any long-term care insurance policy as a replacement for another such policy unless coverage under such replacement policy is available to an individual insured for benefits covered under the previous policy to the same extent as under such previous policy (including every individual insured under a group policy) on the date of termination of such previous policy, without exclusions or limitations that did not apply under such previous policy.

“(B) INSURED’S OPTION TO REDUCE COVERAGE.—In any case where an insured individual covered under a long-term care insurance policy knowingly and voluntarily elects to substitute for such policy a policy that provides less coverage, substitute policy shall be considered a replacement policy for purposes of this title.

"(3) CONTINUATION AND CONVERSION RIGHTS WITH RESPECT TO GROUP POLICIES.—

"(A) IN GENERAL.—Insurers shall be required to include in each group long-term care insurance policy, a provision affording to each insured individual, when such policy would otherwise terminate, the opportunity (at the insurer's option, subject to approval of the State insurance commissioner) either to continue or to convert coverage under such policy in accordance with this paragraph.

"(B) RIGHTS OF RELATED INDIVIDUALS.—In the case of any insured individual whose eligibility for coverage under a group policy is based on relationship to another individual, the insurer shall be required to continue such coverage upon termination of the relationship due to divorce or death.

"(C) CONTINUATION OF COVERAGE.—A group policy shall be considered to meet the requirements of this paragraph with respect to rights of an insured individual to continuation of coverage if coverage of the same (or substantially equivalent) benefits for such individual under such policy is maintained, subject only to timely payment of premiums.

"(D) CONVERSION OF COVERAGE.—A group policy shall be considered to meet the requirements of this paragraph with respect to conversion if it entitles each individual who has been continuously covered under the policy for at least 6 months before the date of the termination to issuance of a replacement policy providing benefits identical to, substantially equivalent to, or in excess of, the benefits under such terminated group policy—

"(i) without requiring evidence of insurability with respect to benefits covered under such previous policy, and

"(ii) at premium rates no higher than would apply if the insured individual had initially obtained coverage under such replacement policy on the date such insured individual initially obtained coverage under such group policy.

"(4) TREATMENT OF SUBSTANTIAL EQUIVALENCE.—

"(A) UNDER SECRETARY'S GUIDELINES.—The Secretary, in consultation with the NAIC, shall develop guidelines for comparing long-term care insurance policies for the purpose of determining whether benefits under such policies are substantially equivalent.

"(B) BEFORE EFFECTIVE DATE OF SECRETARY'S GUIDELINES.—During the period prior to the effective date of guidelines published by the Secretary under this paragraph, insurers shall comply with standards for determinations of substantial equivalence established by State insurance commissioners.

"(5) ADDITIONAL REQUIREMENTS.—Insurers shall comply with such other requirements relating to continuation, renewal, replacement, and conversion of long-term care insurance policies as the Secretary may establish.

"SEC. 2527. REQUIREMENTS RELATING TO PAYMENT OF BENEFITS.

"(a) IN GENERAL.—The Secretary, in consultation with the NAIC, shall promulgate regulations establishing requirements with respect to claims for and payment of benefits under long-term care insurance policies, which shall include at a minimum the requirements specified in this section.

"(b) STANDARDS RELATING TO THRESHOLD CONDITIONS FOR RECEIPT OF COVERED BENEFITS.—

"(1) IN GENERAL.—Each long-term care insurance policy shall specify the level (or levels) of functional or cognitive mental impairment (or combination of impairments) required as a threshold condition of entitlement to receive benefits under the policy (which threshold condition or conditions shall be consistent with any regulations promulgated by the Secretary pursuant to subsection (B)).

"(2) SECRETARIAL RESPONSIBILITY.—The Secretary (in consultation with the NAIC) may promulgate such regulations as the Secretary finds appropriate establishing standardized thresholds to be used under such policies as preconditions for varying levels of benefits.

"(c) REQUIREMENTS RELATING TO CLAIMS FOR BENEFITS.—

"(1) IN GENERAL.—Insurers shall be required—

"(A) to promptly pay or deny claims for benefits submitted by (or on behalf of) insured individuals who have been determined pursuant to subsection (b) to meet the threshold conditions for payment of benefits;

"(B) to provide an explanation in writing of the reasons for payment, partial payment, or denial of each such claim and of grievance procedures available to the policyholder; and

"(C) to provide an administrative procedure under which an insured individual may seek reconsideration of any denial or partial payment of a claim.

"(2) APPEAL TO STATE COMPLAINT REVIEW OFFICE.—

"(A) IN GENERAL.—In the event of such a disagreement or inconsistencies, an individual policyholder may appeal an insurer's decision to the complaint review office established by the State under section 9024. The complaint review office shall use appropriately trained individuals in cases involving long-term care insurance disputes under this section.

"(B) FURTHER REVIEW.—Any decision made by such an office shall not be binding.

"(C) CONSTRUCTION.—Nothing in this paragraph shall prohibit an individual from seeking judicial review with respect to such a disagreement or inconsistencies.

"PART C—DEFINITIONS

"SEC. 2541. DEFINITIONS.

"For purposes of this title:

"(1) ACTIVITY OF DAILY LIVING.—The term 'activity of daily living' means any of the following: eating, toileting, dressing, bathing, and transferring.

"(2) ADULT DAY CARE.—The term 'adult day care' means a program providing social and health-related services during the day to six or more adults with disabilities (or such smaller number as the Secretary may specify in regulations) in a community group setting outside the home.

"(3) CERTIFICATE.—The term 'certificate' means a document issued to an individual as evidence of such individual's coverage under a group insurance policy.

"(4) DESIGNATED REPRESENTATIVE.—The term 'designated representative' means the person designated by an insured individual (or, if such individual is incapacitated, pursuant to an appropriate administrative or judicial procedure) to communicate with the insurer on behalf of such individual in the event of such individual's incapacitation.

"(5) HOME HEALTH CARE.—The term 'home health care' means medical and nonmedical services including such services as homemaker services, assistance with activities of daily living, and respite care provided to individuals in their residences.

"(6) INSURED INDIVIDUAL.—The term 'insured individual' means, with respect to a long-term care insurance policy, any individual who has coverage of benefits under such policy.

"(7) INSURER.—The term 'insurer' means any person that offers or sells an individual or group long-term care insurance policy under which such person is at risk for all or part of the cost of benefits under the policy, and includes any agent of such person.

"(8) LONG-TERM CARE INSURANCE POLICY.—

"(A) IN GENERAL.—The term 'long-term care insurance policy' means any insurance policy or rider advertised, marketed, offered, or designed to provide coverage for each covered person on an expense incurred, indemnity, prepaid, or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital.

"(B) INCLUSIONS.—Such term includes a group or individual annuity or life insurance policy or rider which provides directly (or which supplements) long-term care insurance. Such term also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity.

"(C) POLICIES EXCLUDED.—Except as provided in subparagraphs (D) and (E), in this title the term 'long-term care insurance policy' does not include any medicare supplemental policy (as defined in section 1882(g) of the Social Security Act) and any insurance which is offered primarily to provide—

"(i) basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, or major medical expense coverage,

"(ii) disability income or related asset-protection coverage,

"(iii) accident only coverage,

"(iv) specified disease or specified accident coverage, or

"(v) limited benefit health coverage.

"(D) INCLUSION OF POLICIES MARKETED AS LONG-TERM CARE INSURANCE.—In this title, the term 'long-term care insurance policy' also includes any product which is advertised, marketed, or offered as long-term care insurance.

"(E) DISCLOSURE REQUIREMENTS FOR CERTAIN DISABILITY INCOME POLICIES AND LIFE INSURANCE POLICIES.—

"(i) IN GENERAL.—In this title, the term 'long-term care insurance policy' includes—

"(I) a policy described in subparagraph (C)(ii) under which the eligibility or amount of benefits are based on an assessment of functional ability (based on activities of daily living or otherwise), or

"(II) a life insurance policy described in clause (iii), if the disclosure requirements of clause (ii) are not met.

"(ii) DISCLOSURE REQUIREMENTS.—The disclosure requirements of this clause (ii) for a policy are that—

"(I) the policy discloses (in a form and manner specified in the standards under this title) the fact that the policy is not a long-term care insurance policy;

"(II) the policy outlines how the benefits in the policy differ from the benefits required to be provided under such standards of a long-term care insurance policy; and

"(III) in the case of a life-insurance policy described in clause subparagraph (D), at the time of policy delivery there is provided to the purchaser and the beneficiary a policy summary described in clause (iv).

"(iii) CERTAIN LIFE INSURANCE POLICIES.—A life insurance policy described in this clause is one—

"(I) which accelerates the death benefit specifically for one or more of the qualifying events of terminal illness, for medical conditions requiring extraordinary medical intervention, or for permanent institutional confinement;

"(II) which provides the option of a lump-sum payment for those benefits; or

"(III) which provides benefits based on the use of nursing facility care.

"(iv) POLICY SUMMARY.—A policy summary described in this clause is such a summary that includes—

"(I) an explanation of how the long-term care benefits interact with other components of the policy (including deductions from death benefits);

"(II) a description of the amount and length of benefits and the guaranteed lifetime benefits (if any) for each covered individual; and

"(III) any exclusions, reductions, and limitations on benefits of long-term care.

"(9) NURSING FACILITY.—The term 'nursing facility' means a facility licensed by the State to provide to residents—

"(A) skilled nursing care and related services for residents who require medical or nursing care;

"(B) rehabilitation services for the rehabilitation of injured, disabled, or sick individuals, or

"(C) on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities.

"(10) POLICYHOLDER.—The term 'policyholder' means the entity which is the holder of record of a group long-term care insurance policy.

"(11) RESIDENTIAL CARE FACILITY.—The term 'residential care facility' means a facility (including a nursing facility) that—

"(A) provides to residents medical or personal care services (including at a minimum assistance with activities of daily living) in a setting other than an individual or single-family home, and

"(B) does not provide services of a higher level than can be provided by a nursing facility.

"(12) RESPITE CARE.—The term 'respite care' means the temporary provision of care (including assistance with activities of daily living) to an individual, in the individual's home or another setting in the community, for the purpose of

affording such individual's unpaid caregiver a respite from the responsibilities of such care.

"(13) STATE INSURANCE COMMISSIONER.—The term 'State insurance commissioner' means the State official bearing such title, or, in the case of a jurisdiction where such title is not used, the State official with primary responsibility for the regulation of insurance."

(b) DEFINITION OF STATE.—Section 1101(a)(1) of the Social Security Act (42 U.S.C. 1301(a)(1)), as amended by sections 8001(b)(4) and 10001(b), is amended by striking "or title XXIV" and inserting " , title XXIV, or title XXV".

TITLE XI—REVENUE PROVISIONS

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SEC. 11001. AMENDMENT OF 1986 CODE.

Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

Subtitle A—Increase In Excise Taxes On Tobacco Products

SEC. 11101. INCREASE IN EXCISE TAXES ON TOBACCO PRODUCTS.

(a) CIGARETTES.—Subsection (b) of section 5701 is amended by striking paragraph (1) and all that follows and inserting the following:

“(1) SMALL CIGARETTES.—On cigarettes, weighing not more than 3 pounds per thousand, the amount per thousand determined under the following table:

“In the case of cigarettes removed—	The tax per thousand is—
After July 31, 1995, and before January 1, 1997	\$19.50
During 1997	\$24.50
During 1998	\$29.50
After December 31, 1998	\$34.50.

“(2) LARGE CIGARETTES.—On cigarettes, weighing more than 3 pounds per thousand, removed at any time, an amount per thousand equal to 2.1 times the tax per thousand imposed by paragraph (1) on cigarettes removed at such time; except that, if more than 6½ inches in length, they shall be taxable at the rate prescribed for cigarettes weighing not more than 3 pounds per thousand, counting each 2¾ inches, or fraction thereof, of the length of each as one cigarette.”

(b) CIGARS.—Paragraphs (1) and (2) of section 5701(a) are amended to read as follows:

“(1) SMALL CIGARS.—On cigars, weighing not more than 3 pounds per thousand, the amount per thousand determined under the following table:

“In the case of cigars removed—	The tax per thousand is—
After July 31, 1995, and before January 1, 1997	\$1.83
During 1997	\$2.30
During 1998	\$2.77
After December 31, 1998	\$3.23.

“(2) LARGE CIGARS.—On cigars, weighing more than 3 pounds per thousand, the applicable percentage (determined under the following table) of the price for which sold but not more than the applicable limitation (determined under such table) per thousand:

In the case of cigars removed—	The applicable percentage is—	The limitation is—
After July 31, 1995 and before January 1, 1997	21 percent	\$48.75
During 1997	26 percent	\$61.26
During 1998	31 percent	\$73.74
After December 31, 1998	37 percent	\$86.25.”

(c) CIGARETTE PAPERS.—Subsection (c) of section 5701 is amended—

(1) by striking “0.75 cent (0.625 cent on cigarette papers removed during 1991 or 1992)” and inserting “the amount determined in accordance with the following table”, and

(2) by adding at the end the following:

“In the case of cigarette papers removed—	The tax for each 50 papers is—
After July 31, 1995 and before January 1, 1997	1.22 cents
During 1997	1.53 cents

"In the case of cigarette papers removed—**The tax for
each 50 pa-
pers is—**

During 1998	1.84 cents
After December 31, 1998	2.16 cents."

(d) CIGARETTE TUBES.—Subsection (d) of section 5701 is amended—

(1) by striking "1.5 cents (1.25 cents on cigarette tubes removed during 1991 or 1992)" and inserting "the amount determined in accordance with the following table", and

(2) by adding at the end the following:

"In the case of cigarette tubes removed—**The tax for
each 50
tubes is—**

After July 31, 1995 and before January 1, 1997	2.44 cents
During 1997	3.06 cents
During 1998	3.69 cents
After December 31, 1998	4.31 cents."

(e) SNUFF.—Paragraph (1) of section 5701(e) is amended—

(1) by striking "36 cents (30 cents on snuff removed during 1991 or 1992)" and inserting "the amount determined in accordance with the following table", and

(2) by adding at the end the following:

"In the case of snuff removed—**The tax per
pound is—**

After July 31, 1995 and before January 1, 1997	58.5 cents
During 1997	73.5 cents
During 1998	88.5 cents
After December 31, 1998	\$1.03½."

(f) CHEWING TOBACCO.—Paragraph (2) of section 5701(e) is amended—

(1) by striking "12 cents (10 cents on chewing tobacco removed during 1991 or 1992)" and inserting "the amount determined in accordance with the following table", and

(2) by adding at the end the following:

"In the case of chewing tobacco removed—**The tax per
pound is—**

After July 31, 1995 and before January 1, 1997	19.5 cents
During 1997	24.5 cents
During 1998	29.5 cents
After December 31, 1998	34.5 cents."

(g) PIPE TOBACCO.—Subsection (f) of section 5701 is amended—

(1) by striking "67.5 cents (56.25 cents on pipe tobacco removed during 1991 or 1992)" and inserting "the amount determined in accordance with the following table", and

(2) by adding at the end the following:

"In the case of pipe tobacco removed—**The tax per
pound is—**

After July 31, 1995 and before January 1, 1997	\$1.10
During 1997	\$1.38
During 1998	\$1.66
After December 31, 1998	\$1.94."

(h) APPLICATION OF TAX INCREASE TO PUERTO RICO.—Section 5701 is amended by adding at the end the following new subsection:

"(h) APPLICATION OF TAXES TO PUERTO RICO.—Notwithstanding subsections (b) and (c) of section 7653 and any other provision of law—

"(1) IN GENERAL.—On tobacco products and cigarette papers and tubes, manufactured in or imported into the Commonwealth of Puerto Rico, there is hereby imposed a tax at the rate equal to the excess of—

"(A) the rate of tax applicable under this section to like articles manufactured in the United States, over

"(B) the rate referred to in subparagraph (A) as in effect on the day before the date of the enactment of the Health Security Act.

"(2) SHIPMENTS TO PUERTO RICO FROM THE UNITED STATES.—Only the rates of tax in effect on the day before the date of the enactment of the Health Security Act shall be taken into account in determining the amount of any exemption from, or credit or drawback of, any tax imposed by this section on any article shipped to the Commonwealth of Puerto Rico from the United States.

"(3) SHIPMENTS FROM PUERTO RICO TO THE UNITED STATES.—The rates of tax taken into account under section 7652(a) with respect to tobacco products and cigarette papers and tubes coming into the United States from the Commonwealth of Puerto Rico shall be the rates of tax in effect on the day before the date of the enactment of the Health Security Act.

"(4) DISPOSITION OF REVENUES.—The provisions of section 7652(a)(3) shall not apply to any tax imposed by reason of this subsection."

(i) EFFECTIVE DATE.—The amendments made by this section shall apply to articles removed (as defined in section 5702(k) of the Internal Revenue Code of 1986, as amended by this Act) after July 31, 1995.

(j) FLOOR STOCKS TAXES.—

(1) IMPOSITION OF TAX.—On tobacco products and cigarette papers and tubes manufactured in or imported into the United States or the Commonwealth of Puerto Rico which are removed before any tax-increase date and held on such date for sale by any person, there is hereby imposed a tax in an amount equal to the excess of—

(A) the tax which would be imposed under section 5701 of the Internal Revenue Code of 1986 on the article if the article had been removed on such date, over

(B) the prior tax (if any) imposed under section 5701 or 7652 of such Code on such article.

(2) AUTHORITY TO EXEMPT CIGARETTES HELD IN VENDING MACHINES.—To the extent provided in regulations prescribed by the Secretary, no tax shall be imposed by paragraph (1) on cigarettes held for retail sale on any tax-increase date, by any person in any vending machine. If the Secretary provides such a benefit with respect to any person, the Secretary may reduce the \$500 amount in paragraph (3) with respect to such person.

(3) CREDIT AGAINST TAX.—Each person shall be allowed as a credit against the taxes imposed by paragraph (1) on each tax-increase date an amount equal to \$500. Such credit shall not exceed the amount of taxes imposed by paragraph (1) on such date for which such person is liable.

(4) LIABILITY FOR TAX AND METHOD OF PAYMENT.—

(A) LIABILITY FOR TAX.—A person holding any article on any tax-increase date to which any tax imposed by paragraph (1) applies shall be liable for such tax.

(B) METHOD OF PAYMENT.—The tax imposed by paragraph (1) shall be paid in such manner as the Secretary shall prescribe by regulations.

(C) TIME FOR PAYMENT.—The tax imposed by paragraph (1) on any tax-increase date shall be paid on or before the date which is 3 months after such tax-increase date.

(5) ARTICLES IN FOREIGN TRADE ZONES.—Notwithstanding the Act of June 18, 1934 (48 Stat. 998, 19 U.S.C. 81a) and any other provision of law, any article which is located in a foreign trade zone on any tax-increase date shall be subject to the taxes imposed by paragraph (1) if—

(A) internal revenue taxes have been determined, or customs duties liquidated, with respect to such article before such date pursuant to a request made under the 1st proviso of section 3(a) of such Act, or

(B) such article is held on such date under the supervision of a customs officer pursuant to the 2d proviso of such section 3(a).

(6) DEFINITIONS.—For purposes of this subsection—

(A) TAX-INCREASE DATE.—The term "tax-increase date" means August 1, 1995, January 1, 1997, January 1, 1998, and January 1, 1999.

(B) OTHER DEFINITIONS.—Terms used in this subsection which are also used in section 5702 of the Internal Revenue Code of 1986 shall have the

respective meanings such terms have in such section, as amended by this Act.

(C) SECRETARY.—The term “Secretary” means the Secretary of the Treasury or his delegate.

(7) CONTROLLED GROUPS.—Rules similar to the rules of section 5061(e)(3) of such Code shall apply for purposes of this subsection.

(8) OTHER LAWS APPLICABLE.—All provisions of law, including penalties, applicable with respect to the taxes imposed by section 5701 of such Code shall, insofar as applicable and not inconsistent with the provisions of this subsection, apply to the floor stocks taxes imposed by paragraph (1), to the same extent as if such taxes were imposed by such section 5701. The Secretary may treat any person who bore the ultimate burden of the tax imposed by paragraph (1) as the person to whom a credit or refund under such provisions may be allowed or made.

SEC. 11102. MODIFICATIONS OF CERTAIN TOBACCO TAX PROVISIONS.

(a) EXEMPTION FOR EXPORTED TOBACCO PRODUCTS AND CIGARETTE PAPERS AND TUBES TO APPLY ONLY TO ARTICLES MARKED FOR SHIPMENT FROM THE UNITED STATES.—

(1) Subsection (b) of section 5704 is amended by adding at the end the following new sentence: “Tobacco products and cigarette papers and tubes may not be transferred or removed under this subsection unless such products or papers and tubes bear such marks, labels, or notices as the Secretary shall by regulations prescribe.”

(2) Section 5761 is amended by redesignating subsections (c) and (d) as subsections (d) and (e), respectively, and by inserting after subsection (b) the following new subsection:

“(c) SALE OF TOBACCO PRODUCTS AND CIGARETTE PAPERS AND TUBES FOR EXPORT.—Except as provided in subsections (b) and (d) of section 5704—

“(1) every person who sells, relands, or receives within the jurisdiction of the United States any tobacco products or cigarette papers or tubes which have been labeled or shipped for exportation under this chapter,

“(2) every person who sells or receives such relanded tobacco products or cigarette papers or tubes, and

“(3) every person who aids or abets in such selling, relanding, or receiving, shall, in addition to the tax and any other penalty provided in this title, be liable for a penalty equal to the greater of \$1,000 or 5 times the amount of the tax imposed by this chapter. All tobacco products and cigarette papers and tubes relanded within the jurisdiction of the United States, and all vessels, vehicles, and aircraft used in such relanding or in removing such products, papers, and tubes from the place where relanded, shall be forfeited to the United States.”

(3) Subsection (a) of section 5761 is amended by striking “subsection (b)” and inserting “subsection (b) or (c)”.

(4) Subsection (d) of section 5761, as redesignated by paragraph (2), is amended by striking “The penalty imposed by subsection (b)” and inserting “The penalties imposed by subsections (b) and (c)”.

(5)(A) Subchapter F of chapter 52 is amended by adding at the end the following new section:

“SEC. 5754. RESTRICTION ON IMPORTATION OF PREVIOUSLY EXPORTED TOBACCO PRODUCTS.

“(a) IN GENERAL.—Tobacco products and cigarette papers and tubes previously exported from the United States may be imported or brought into the United States only as provided in section 5704(d). For purposes of this section, section 5704(d), section 5761, and such other provisions as the Secretary may specify by regulations, references to exportation shall be treated as including a reference to shipment to the Commonwealth of Puerto Rico.

“(b) CROSS REFERENCE.—

“For penalty for the sale of tobacco products and cigarette papers and tubes in the United States which are labeled for export, see section 5761(c).”

(B) The table of sections for subchapter F of chapter 52 is amended by adding at the end thereof the following new item:

“Sec. 5754. Restriction on importation of previously exported tobacco products.”

(b) IMPORTERS REQUIRED TO BE QUALIFIED.—

(1) Sections 5712, 5713(a), 5721, 5722, 5762(a)(1), and 5763(b) and (c) are each amended by inserting “or importer” after “manufacturer”.

(2) The heading of subsection (b) of section 5763 is amended by inserting "QUALIFIED IMPORTERS," after "MANUFACTURERS,".

(3) The heading for subchapter B of chapter 52 is amended by inserting "and Importers" after "Manufacturers".

(4) The item relating to subchapter B in the table of subchapters for chapter 52 is amended by inserting "and importers" after "manufacturers".

(c) REPEAL OF TAX-EXEMPT SALES TO EMPLOYEES OF CIGARETTE MANUFACTURERS.—

(1) Subsection (a) of section 5704 is amended—

(A) by striking "EMPLOYEE USE OR" in the heading, and

(B) by striking "for use or consumption by employees or" in the text.

(2) Subsection (e) of section 5723 is amended by striking "for use or consumption by their employees, or for experimental purposes" and inserting "for experimental purposes".

(d) REPEAL OF TAX-EXEMPT SALES TO UNITED STATES.—Subsection (b) of section 5704 is amended by striking "and manufacturers may similarly remove such articles for use of the United States;".

(e) BOOKS OF 25 OR FEWER CIGARETTE PAPERS SUBJECT TO TAX.—Subsection (c) of section 5701 is amended by striking "On each book or set of cigarette papers containing more than 25 papers," and inserting "On cigarette papers,".

(f) STORAGE OF TOBACCO PRODUCTS.—Subsection (k) of section 5702 is amended by inserting "under section 5704" after "internal revenue bond".

(g) AUTHORITY TO PRESCRIBE MINIMUM MANUFACTURING ACTIVITY REQUIREMENTS.—Section 5712 is amended by striking "or" at the end of paragraph (1), by redesignating paragraph (2) as paragraph (3), and by inserting after paragraph (1) the following new paragraph:

"(2) the activity proposed to be carried out at such premises does not meet such minimum capacity or activity requirements as the Secretary may prescribe; or".

(h) LIMITATION ON COVER OVER OF TAX ON TOBACCO PRODUCTS.—Section 7652 is amended by adding at the end thereof the following new subsection:

"(h) LIMITATION ON COVER OVER OF TAX ON TOBACCO PRODUCTS.—For purposes of this section, with respect to taxes imposed under section 5701 or this section on any tobacco product or cigarette paper or tube, the amount covered into the treasuries of Puerto Rico and the Virgin Islands shall not exceed the rate of tax under section 5701 in effect on the article on the day before the date of the enactment of the Health Security Act."

(i) EFFECTIVE DATE.—The amendments made by this section shall apply to articles removed (as defined in section 5702(k) of the Internal Revenue Code of 1986, as amended by this Act) after July 31, 1995.

SEC. 11103. IMPOSITION OF EXCISE TAX ON MANUFACTURE OR IMPORTATION OF ROLL-YOUR-OWN TOBACCO.

(a) IN GENERAL.—Section 5701 (relating to rate of tax), as amended by section 11101, is amended by redesignating subsections (g) and (h) as subsections (h) and (i), respectively, and by inserting after subsection (f) the following new subsection:

"(g) ROLL-YOUR-OWN TOBACCO.—On roll-your-own tobacco, manufactured in or imported into the United States, there shall be imposed a tax of the amount determined in accordance with the following table per pound (and a proportionate tax at the like rate on all fractional parts of a pound).

"In the case of roll-your-own tobacco removed—

The tax per pound is—

After July 31, 1995 and before January 1, 1997	\$1.10
During 1997	\$1.38
During 1998	\$1.66
After December 31, 1998	\$1.94."

(b) ROLL-YOUR-OWN TOBACCO.—Section 5702 (relating to definitions) is amended by adding at the end the following new subsection:

"(p) ROLL-YOUR-OWN TOBACCO.—The term 'roll-your-own tobacco' means any tobacco which, because of its appearance, type, packaging, or labeling, is suitable for use and likely to be offered to, or purchased by, consumers as tobacco for making cigarettes."

(c) TECHNICAL AMENDMENTS.—

(1) Subsection (c) of section 5702 is amended by striking "and pipe tobacco" and inserting "pipe tobacco, and roll-your-own tobacco".

(2) Subsection (d) of section 5702 is amended—

(A) in the material preceding paragraph (1), by striking “or pipe tobacco” and inserting “pipe tobacco, or roll-your-own tobacco”, and

(B) by striking paragraph (1) and inserting the following new paragraph:

“(1) a person who produces cigars, cigarettes, smokeless tobacco, pipe tobacco, or roll-your-own tobacco solely for his own personal consumption or use, and”.

(3) The chapter heading for chapter 52 is amended to read as follows:

“CHAPTER 52—TOBACCO PRODUCTS AND CIGARETTE PAPERS AND TUBES”.

(4) The table of chapters for subtitle E is amended by striking the item relating to chapter 52 and inserting the following new item:

“Chapter 52. Tobacco products and cigarette papers and tubes.”

(d) **EFFECTIVE DATE.**—

(1) **IN GENERAL.**—The amendments made by this section shall apply to roll-your-own tobacco removed (as defined in section 5702(k) of the Internal Revenue Code of 1986, as amended by this Act) after July 31, 1995.

(2) **TRANSITIONAL RULE.**—Any person who—

(A) on the date of the enactment of this Act is engaged in business as a manufacturer of roll-your-own tobacco or as an importer of tobacco products or cigarette papers and tubes, and

(B) before August 1, 1995, submits an application under subchapter B of chapter 52 of such Code to engage in such business, may, notwithstanding such subchapter B, continue to engage in such business pending final action on such application. Pending such final action, all provisions of such chapter 52 shall apply to such applicant in the same manner and to the same extent as if such applicant were a holder of a permit under such chapter 52 to engage in such business.

Subtitle B—Treatment of Employer-Provided Health Care

SEC. 11201. HEALTH BENEFITS MAY NOT BE PROVIDED UNDER CAFETERIA PLANS OR FLEXIBLE SPENDING ARRANGEMENTS OTHER THAN MEDICAL SAVINGS ACCOUNTS.

(a) **CAFETERIA PLANS.**—

(1) **IN GENERAL.**—Subsection (f) of section 125 (defining qualified benefits) is amended by adding at the end the following new sentence: “Such term shall not include any benefits or coverage under an accident or health plan.”

(2) **CONFORMING AMENDMENT.**—Subsection (g) of section 125 is amended by striking paragraph (2) and redesignating paragraphs (3) and (4) as paragraphs (2) and (3), respectively.

(b) **FLEXIBLE SPENDING ARRANGEMENTS.**—The text of section 106 (relating to contributions by employer to accident and health plans) is amended to read as follows:

“(a) **GENERAL RULE.**—Except as provided in subsection (b), gross income of an employee does not include employer-provided coverage under an accident or health plan.

“(b) **NO EXCLUSION FOR COVERAGE PROVIDED UNDER FLEXIBLE SPENDING ARRANGEMENTS.**—

“(1) **IN GENERAL.**—Subsection (a) shall not apply to coverage provided through a flexible spending or similar arrangement.

“(2) **FLEXIBLE SPENDING ARRANGEMENT.**—For purposes of this subsection, a flexible spending arrangement is a benefit program which provides employees with coverage under which—

“(A) specified incurred expenses may be reimbursed (subject to reimbursement maximums and other reasonable conditions), and

“(B) the maximum amount of reimbursement which is reasonably available to a participant for such coverage is less than 500 percent of the cost of such coverage.

In the case of an insured plan, the maximum amount reasonably available shall be determined on the basis of the underlying coverage.

“(c) **CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.**—

“(1) **IN GENERAL.**—Notwithstanding subsection (b), gross income of an eligible employee does not include amounts contributed by an employer to any medical savings account of such employee to the extent such contributions are required to be made to such account by such employer under section 3466(d)(2)(C). For

purposes of the preceding sentence, the terms 'eligible employee' and 'medical savings account' have the respective meanings given such terms by section 7705.

"(2) NO CONSTRUCTIVE RECEIPT.—No amount shall be included in the gross income of any employee solely because the employee may choose between the contributions referred to in paragraph (1) and employer contributions to another health plan of the employer."

(c) MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Chapter 79 is amended by adding at the end the following new section:

"SEC. 7705. MEDICAL SAVINGS ACCOUNTS.

"(a) GENERAL RULE.—For purposes of this title, the term 'medical savings account' means a trust created or organized in the United States for the exclusive benefit of an individual or his beneficiaries, but only if the written instrument creating the trust meets the following requirements:

"(1) Except in the case of a rollover contribution described in subsection (d)(3), no contribution will be accepted unless—

"(A) it is in cash, and

"(B) such individual is an eligible employee for the period for which such contribution is made.

"(2) The trustee is a bank (as defined in section 408(n)), insurance company (as defined in section 816), or such other person who demonstrates to the satisfaction of the Secretary that the manner in which such other person will administer the trust will be consistent with the requirements of this section.

"(3) No part of the trust funds will be invested in life insurance contracts.

"(4) The interest of an individual in the balance of the account is nonforfeitable.

"(5) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

(b) ELIGIBLE EMPLOYEE.—For purposes of this section—

"(1) IN GENERAL.—The term 'eligible employee' means any employee who is covered under a high deductible plan (as defined in section 2204(5) of the Health Security Act) of his employer.

"(2) EXCEPTION.—An employee shall be treated as not being an eligible employee for any calendar year if—

"(A) for any month during such year, it is reasonably expected that such employee will be eligible for subsidies under subpart 2 of part B of title XXIII of the Social Security Act, or

"(B) it is reasonably expected that, if the employee were a medicare part C covered individual for any month during such year, the amount of tax imposed by section 59B (if any) on such employee would be determined under section 59B(b).

(c) TAX TREATMENT OF ACCOUNTS.—

"(1) ACCOUNT TAXED AS GRANTOR TRUST.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the account beneficiary of a medical savings account shall be treated for purposes of this title as the owner of such account and shall be subject to tax thereon in accordance with subpart E of part I of subchapter J of this chapter (relating to grantors and others treated as substantial owners).

"(B) TREATMENT OF CAPITAL LOSSES.—With respect to assets held in a medical savings account, any capital loss for a taxable year from the sale or exchange of such an asset shall be allowed only to the extent of capital gains from such assets for such taxable year. Any capital loss which is disallowed under the preceding sentence shall be treated as a capital loss from the sale or exchange of such an asset in the next taxable year. For purposes of this subparagraph, all medical savings accounts of the account beneficiary shall be treated as 1 account.

"(2) ACCOUNT TERMINATES IF INDIVIDUAL ENGAGES IN PROHIBITED TRANSACTION.—

"(A) IN GENERAL.—If, during any taxable year of the account beneficiary, such beneficiary engages in any transaction prohibited by section 4975 with respect to the account, the account shall cease to be a medical savings account as of the first day of such taxable year.

"(B) ACCOUNT TREATED AS DISTRIBUTING ALL ITS ASSETS.—In any case in which any account ceases to be a medical savings account by reason of subparagraph (A) on the first day of any taxable year, subsection (d) shall be applied as if—

"(i) there were a distribution on such first day in an amount equal to the fair market value (on such first day) of all assets in the account (on such first day), and

"(ii) no portion of such distribution were used to pay qualified medical expenses.

"(3) EFFECT OF PLEDGING ACCOUNT AS SECURITY.—If, during any taxable year, the account beneficiary uses the account or any portion thereof as security for a loan, the portion so used is treated as distributed and not used to pay qualified medical expenses.

"(d) TAX TREATMENT OF DISTRIBUTIONS.—

"(1) INCLUSION OF AMOUNTS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

"(A) IN GENERAL.—Any amount paid or distributed out of a medical savings account which is not used exclusively to pay the qualified medical expenses of the account beneficiary or of the spouse or young dependents (as defined in section 59B(e)(5)) of such beneficiary shall be included in the gross income of such beneficiary to the extent such amount does not exceed the excess of—

"(i) the aggregate contributions to such account which were not includible in gross income by reason of section 106(c), over

"(ii) the aggregate prior payments or distributions from such account which were includible in gross income under this paragraph.

"(B) SPECIAL RULES.—For purposes of subparagraph (A)—

"(i) all medical savings accounts of the account beneficiary shall be treated as 1 account,

"(ii) all payments and distributions during any taxable year shall be treated as 1 distribution, and

"(iii) any distribution of property shall be taken into account at its fair market value on the date of the distribution.

"(2) PENALTY FOR DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

"(A) IN GENERAL.—The tax imposed by chapter 1 on the account beneficiary for any taxable year in which there is a payment or distribution from a medical savings account of such beneficiary which is includible in gross income under paragraph (1) shall be increased by 100 percent of the amount which is so includible.

"(B) EXCEPTION FOR DISTRIBUTIONS AFTER AGE 65.—Subparagraph (A) shall not apply to any payment or distribution after the date on which the account beneficiary attains age 65.

"(C) EXCEPTION FOR DISABILITY OR DEATH.—Subparagraph (A) shall not apply if the payment or distribution is made after the account beneficiary becomes disabled within the meaning of section 72(m)(7) or dies.

"(3) ROLLOVER CONTRIBUTION.—An amount is described in this paragraph as a rollover contribution if it meets the requirements of subparagraphs (A) and (B).

"(A) IN GENERAL.—Paragraph (1) shall not apply to any amount paid or distributed from a medical savings account to the account beneficiary to the extent the amount received is paid into a medical savings account for the benefit of such beneficiary not later than the 60th day after the day on which he receives the payment or distribution.

"(B) LIMITATION.—This paragraph shall not apply to any amount described in subparagraph (A) received by an individual from a medical savings account if, at any time during the 1-year period ending on the day of such receipt, such individual received any other amount described in subparagraph (A) from a medical savings account which was not includible in his gross income because of the application of this paragraph.

"(4) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—For purposes of section 213, any payment or distribution out of a medical savings account for qualified medical expenses shall not be treated as an expense paid for medical care to the extent of the amount of such payment or distribution which is excludable from gross income solely by reason of paragraph (1)(A).

"(e) DEFINITIONS.—For purposes of this section—

"(1) QUALIFIED MEDICAL EXPENSES.—The term 'qualified medical expenses' means any expense for medical care (as defined in section 213(d)); except that such term shall not include any expense for insurance.

"(2) ACCOUNT BENEFICIARY.—The term 'account beneficiary' means the individual for whose benefit the medical savings account is maintained.

"(f) CUSTODIAL ACCOUNTS.—For purposes of this section, a custodial account shall be treated as a trust if—

"(1) the assets of such account are held by a bank (as defined in section 408(n)), insurance company (as defined in section 816), or another person who demonstrates to the satisfaction of the Secretary that the manner in which he will administer the account will be consistent with the requirements of this section, and

"(2) the custodial account would, except for the fact that it is not a trust, constitute a medical savings account described in subsection (a).

For purposes of this title, in the case of a custodial account treated as a trust by reason of the preceding sentence, the custodian of such account shall be treated as the trustee thereof.

"(g) REPORTS.—The trustee of a medical savings account shall keep such records and make such reports regarding such account to the Secretary and to the account beneficiary with respect to contributions, distributions, and such other matters as the Secretary may require under regulations. The reports required by this subsection shall be filed at such time and in such manner and furnished to such individuals at such time and in such manner as may be required by such regulations."

(2) EMPLOYER PAYMENTS EXCLUDED FROM EMPLOYMENT TAX BASE.—

(A) SOCIAL SECURITY TAXES.—

(i) Subsection (a) of section 3121 is amended by striking "or" at the end of paragraph (20), by striking the period at the end of paragraph (21) and inserting "; or", and by inserting after paragraph (21) the following new paragraph:

"(22) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(c)."

(ii) Subsection (a) of section 209 of the Social Security Act is amended by striking "or" at the end of paragraph (18), by striking the period at the end of paragraph (19) and inserting "; or", and by inserting after paragraph (19) the following new paragraph:

"(20) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(c) of the Internal Revenue Code of 1986."

(B) RAILROAD RETIREMENT TAX.—Subsection (e) of section 3231 is amended by adding at the end the following new paragraph:

"(10) MEDICAL SAVINGS ACCOUNT CONTRIBUTIONS.—The term 'compensation' shall not include any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(c)."

(C) UNEMPLOYMENT TAX.—Subsection (b) of section 3306 is amended by striking "or" at the end of paragraph (15), by striking the period at the end of paragraph (16) and inserting "; or", and by inserting after paragraph (16) the following new paragraph:

"(17) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(c)."

(D) WITHHOLDING TAX.—Subsection (a) of section 3401 is amended by striking "or" at the end of paragraph (19), by striking the period at the end of paragraph (20) and inserting "; or", and by inserting after paragraph (20) the following new paragraph:

"(21) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(c)."

(3) TAX ON PROHIBITED TRANSACTIONS.—Section 4975 (relating to prohibited transactions) is amended—

(A) by adding at the end of subsection (c) the following new paragraph:

"(4) SPECIAL RULE FOR MEDICAL SAVINGS ACCOUNTS.—An individual for whose benefit a medical savings account (within the meaning of section 7705) is established shall be exempt from the tax imposed by this section with respect to any transaction concerning such account (which would otherwise be taxable under this section) if, with respect to such transaction, the account ceases to be a medical savings account by reason of the application of section 7705(c)(2)(A) to such account.", and

(B) by inserting "or a medical savings account described in section 7705" in subsection (e)(1) after "described in section 408(a)".

(4) FAILURE TO PROVIDE REPORTS ON MEDICAL SAVINGS ACCOUNTS.—Section 6693 (relating to failure to provide reports on individual retirement account or annuities) is amended—

(A) by inserting "OR ON MEDICAL SAVINGS ACCOUNTS" after "ANNUITIES" in the heading of such section, and

(B) by adding at the end of subsection (a) the following: "The person required by section 7705(g) to file a report regarding a medical savings account at the time and in the manner required by such section shall pay a penalty of \$50 for each failure unless it is shown that such failure is due to reasonable cause."

(5) CLERICAL AMENDMENTS.—

(A) The table of sections for chapter 79 is amended by adding at the end the following:

"Sec. 7705. Medical savings accounts."

(B) The table of sections for subchapter B of chapter 68 is amended by inserting "or on medical savings accounts" after "annuities" in the item relating to section 6693.

(d) EMPLOYMENT TAX TREATMENT OF AMOUNT NOT EXCLUDED UNDER SECTION 106.—

(1) SOCIAL SECURITY TAX.—

(A) Subsection (a) of section 3121 is amended by inserting after paragraph (22) the following new sentence:

"Nothing in paragraph (2) shall exclude from the term 'wages' any amount which is required to be included in gross income under section 106(b)."

(B) Subsection (a) of section 209 of the Social Security Act is amended by inserting after paragraph (20) the following new sentence:

"Nothing in paragraph (2) shall exclude from the term 'wages' any amount which is required to be included in gross income under section 106(b) of the Internal Revenue Code of 1986."

(2) RAILROAD RETIREMENT TAX.—Paragraph (1) of section 3231(e) is amended by adding at the end thereof the following new sentence: "Nothing in clause (i) of the second sentence of this paragraph shall exclude from the term 'compensation' any amount which is required to be included in gross income under section 106(b)."

(3) UNEMPLOYMENT TAX.—Subsection (b) of section 3306 is amended by inserting after paragraph (17) the following new sentence:

"Nothing in paragraph (2) shall exclude from the term 'wages' any amount which is required to be included in gross income under section 106(b)."

(4) WAGE WITHHOLDING.—Subsection (a) of section 3401 is amended by adding at the end thereof the following new sentence:

"Nothing in the preceding provisions of this subsection (other than paragraph (21)) shall exclude from the term 'wages' any amount which is required to be included in gross income under section 106(b)."

(e) EFFECTIVE DATE.—

(1) PROVISIONS OTHER THAN MEDICAL SAVINGS ACCOUNTS.—

(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the amendments made by subsections (a) and (d), and so much of the amendment made by subsection (b) as relates to section 106(b) of the Internal Revenue Code of 1986, shall take effect on January 1, 1995.

(B) BENEFITS PROVIDED PURSUANT TO COLLECTIVE BARGAINING AGREEMENTS.—In the case of a cafeteria plan or flexible spending arrangement maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers which was ratified before June 30, 1994, the amendments referred to in subparagraph (A) shall not apply to benefits pursuant to any such agreement provided before the date on which the last of such agreements terminate (determined without regard to any extension thereof on or after June 30, 1994). The preceding sentence shall cease to apply with respect to any such agreement on the effective date of any modification of such agreement on or after June 30, 1994.

(C) STATE AND LOCAL EMPLOYEES COVERED BY COLLECTIVE BARGAINING AGREEMENTS.—In the case of employees of a State or political subdivision thereof—

(i) who are not entitled to the benefits of subparagraph (B),

(ii) who are covered by 1 or more collective bargaining agreements with such State or political subdivision which was ratified before June 30, 1994, and

(iii) who are eligible to participate in a cafeteria plan or flexible spending arrangement which was established by State or local law and which is in effect on such date,

the amendments referred to in subparagraph (A) shall not apply to benefits provided under such plan or arrangement (as in effect on such date) before January 1, 1999.

(2) **MEDICAL SAVINGS ACCOUNTS.**—The amendments made by this section (other than the amendments referred to in paragraph (1)(A)) shall take effect on January 1, 1998.

SEC. 11202. DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS INCREASED AND MADE PERMANENT.

(a) **PROVISION MADE PERMANENT.**—

(1) **IN GENERAL.**—Subsection (l) of section 162 (relating to special rules for health insurance costs of self-employed individuals) is amended by striking paragraph (6).

(2) **EFFECTIVE DATE.**—The amendment made by paragraph (1) shall apply to taxable years beginning after December 31, 1993.

(b) **DEDUCTION INCREASED TO 80 PERCENT.**—

(1) **IN GENERAL.**—Paragraph (1) of section 162(l) is amended by striking “25 percent” and inserting “80 percent”.

(2) **OTHER COVERAGE.**—Subparagraph (B) of section 162(l)(2) is amended to read as follows:

“(B) **OTHER COVERAGE.**—Paragraph (1) shall not apply to any taxpayer for any calendar month for which the taxpayer or the taxpayer’s spouse—

“(i) is normally employed by an employer for at least 25 hours per week, or

“(ii) is eligible to participate in a subsidized health plan maintained by any employer of such taxpayer or spouse.”

(3) **EFFECTIVE DATE.**—The amendments made by this subsection shall apply to taxable years beginning after December 31, 1997.

SEC. 11203. LIMITATION ON PREPAYMENT OF MEDICAL INSURANCE PREMIUMS.

(a) **GENERAL RULE.**—Subsection (d) of section 213 is amended by adding at the end the following new paragraph:

“(10) **LIMITATION ON PREPAYMENTS.**—If the taxpayer pays a premium or other amount which constitutes medical care under paragraph (1), to the extent such premium or other amount is properly allocable to insurance coverage or care to be provided during periods more than 12 months after the month in which such payment is made, such premium shall be treated as paid ratably over the period during which such insurance coverage or care is to be provided. The preceding sentence shall not apply to any premium to which paragraph (7) applies.”

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to amounts paid after December 31, 1994.

Subtitle C—Extending Medicare Coverage of, and Application of Hospital Insurance Tax to, All State and Local Government Employees

SEC. 11301. EXTENDING MEDICARE COVERAGE OF, AND APPLICATION OF HOSPITAL INSURANCE TAX TO, ALL STATE AND LOCAL GOVERNMENT EMPLOYEES.

(a) **IN GENERAL.**—

(1) **APPLICATION OF HOSPITAL INSURANCE TAX.**—Section 3121(u)(2) is amended by striking subparagraphs (C) and (D).

(2) **COVERAGE UNDER MEDICARE.**—Section 210(p) of the Social Security Act (42 U.S.C. 410(p)) is amended by striking paragraphs (3) and (4).

(3) **EFFECTIVE DATE.**—The amendments made by this subsection shall apply to services performed after December 31, 1996.

(b) **PHASEIN OF AMOUNT OF TAX WITH RESPECT TO EMPLOYEES NEWLY SUBJECT TO TAX.**—Subsection (u) of section 3121 is amended by adding at the end the following new paragraph:

“(4) **PHASEIN OF AMOUNT OF TAX WITH RESPECT TO CERTAIN EMPLOYEES.**—If the wages paid to any individual during any period before January 1, 2000, would not be subject to tax under sections 3101(b) and 3111(b) but for the repeal of subparagraphs (C) and (D) of paragraph (2), the rates of the taxes imposed by such sections with respect to such wages paid during such period shall be—

“(A) 0.3625 percent in the case of wages paid during 1997,

“(B) 0.725 percent in the case of wages paid during 1998, and

“(C) 1.0875 percent in the case of wages paid during 1999.”

(c) TRANSITION IN BENEFITS FOR STATE AND LOCAL GOVERNMENT EMPLOYEES AND FORMER EMPLOYEES.—

(1) IN GENERAL.—

(A) **EMPLOYEES NEWLY SUBJECT TO TAX.**—For purposes of sections 226, 226A, and 1811 of the Social Security Act, in the case of any individual who performs services during the calendar quarter beginning January 1, 1997, the wages for which are subject to the tax imposed by section 3101(b) of the Internal Revenue Code of 1986 only because of the amendments made by subsection (a), the individual’s medicare qualified State or local government employment (as defined in subparagraph (B)) performed before January 1, 1997, shall be considered to be “employment” (as defined for purposes of title II of such Act), but only for purposes of providing the individual (or another person) with entitlement to hospital insurance benefits under part A of title XVIII of such Act for months beginning with January 1997.

(B) **MEDICARE QUALIFIED STATE OR LOCAL GOVERNMENT EMPLOYMENT DEFINED.**—In this paragraph, the term “medicare qualified State or local government employment” means medicare qualified government employment described in section 210(p)(1)(B) of the Social Security Act (determined without regard to section 210(p)(3) of such Act, as in effect before its repeal under subsection (a)(2)).

(2) **AUTHORIZATION OF APPROPRIATIONS.**—There are authorized to be appropriated to the Federal Hospital Insurance Trust Fund from time to time such sums as the Secretary of Health and Human Services deems necessary for any fiscal year on account of—

(A) payments made or to be made during such fiscal year from such Trust Fund with respect to individuals who are entitled to benefits under title XVIII of the Social Security Act solely by reason of paragraph (1),

(B) the additional administrative expenses resulting or expected to result therefrom, and

(C) any loss in interest to such Trust Fund resulting from the payment of those amounts, in order to place such Trust Fund in the same position at the end of such fiscal year as it would have been in if this subsection had not been enacted.

(3) **INFORMATION TO INDIVIDUALS WHO ARE PROSPECTIVE MEDICARE BENEFICIARIES BASED ON STATE AND LOCAL GOVERNMENT EMPLOYMENT.**—Section 226(g) of the Social Security Act (42 U.S.C. 426(g)) is amended—

(A) by redesignating paragraphs (1) through (3) as subparagraphs (A) through (C), respectively,

(B) by inserting “(1)” after “(g)”, and

(C) by adding at the end the following new paragraph:

“(2) The Secretary, in consultation with State and local governments, shall provide procedures designed to assure that individuals who perform medicare qualified government employment by virtue of service described in section 210(a)(7) are informed with respect to (A) their eligibility or potential eligibility for hospital insurance benefits (based on such employment) under part A of title XVIII, (B) the requirements for, and conditions of, such eligibility, and (C) the necessity of timely application as a condition of becoming entitled under subsection (b)(2)(C), giving particular attention to individuals who apply for an annuity or retirement benefit and whose eligibility for such annuity or retirement benefit is based on a disability.”

(c) TECHNICAL AMENDMENTS.—

(1) Subparagraph (A) of section 3121(u)(2) is amended by striking “subparagraphs (B) and (C),” and inserting “subparagraph (B),”.

(2) Subparagraph (B) of section 210(p)(1) of the Social Security Act (42 U.S.C. 410(p)(1)) is amended by striking “paragraphs (2) and (3).” and inserting “paragraph (2).”

(3) Section 218 of the Social Security Act (42 U.S.C. 418) is amended by striking subsection (n).

(4) The amendments made by this subsection shall apply after December 31, 1996.

Subtitle D—Treatment of Organizations Providing Health Care Services and Related Organizations

SEC. 11401. QUALIFICATION AND DISCLOSURE REQUIREMENTS FOR CERTAIN NONPROFIT HEALTH CARE ORGANIZATIONS.

(a) TREATMENT OF HOSPITALS AND OTHER ENTITIES PROVIDING HEALTH CARE SERVICES.—Section 501 (relating to exemption from tax on corporations, certain trusts, etc.) is amended by redesignating subsection (n) as subsection (o) and by inserting after subsection (m) the following new subsection:

“(n) QUALIFICATION OF HEALTH CARE ORGANIZATIONS AS EXEMPT ORGANIZATIONS.—

“(1) IN GENERAL.—An organization which is described in paragraph (3) or (4) of subsection (c) and the predominant activity of which is the provision of health care services shall be exempt from tax under subsection (a) only if—

“(A) such organization, with the participation of community representatives, annually—

“(i) assesses its community’s needs for health care services and qualified outreach services, and

“(ii) prepares a written plan to meet those needs,

“(B) pursuant to such plan, such organization provides (directly or indirectly) significant qualified outreach services,

“(C) at least 80 percent of the members of the board of directors of such organization are independent members,

“(D) such organization does not discriminate against individuals in the provision of health care services on the basis of participation in a government-sponsored health plan,

“(E) such organization does not discriminate against individuals in the provision of emergency health care services on the basis of ability to pay, and

“(F) to the extent of such organization’s financial ability, such organization does not discriminate against individuals in the provision of medically necessary health care services (other than emergency services) on the basis of ability to pay.

“(2) SPECIAL RULE FOR HEALTH MAINTENANCE ORGANIZATIONS.—A health maintenance organization shall not be treated as described in subsection (c)(3) unless substantially all of its primary care health services is provided as described in subsection (m)(6)(A).

“(3) DEFINITIONS.—For purposes of this subsection—

“(A) QUALIFIED OUTREACH SERVICES.—The term ‘qualified outreach services’ means health care services (or preventive care, educational, or social services programs related thereto) which are provided—

“(i) in 1 or more medically underserved areas, or

“(ii) at below cost to individuals who are otherwise unable to afford such services.

Such term shall not include insurance described in subparagraph (B)(iii) unless such insurance is provided on a subsidized basis.

“(B) HEALTH CARE SERVICES.—The term ‘health care services’ means—

“(i) any activity of providing medical care (as defined in section 213(d)(1)(A)) to individuals,

“(ii) in the case of an organization described in subsection (c)(3), any activity which is treated as accomplishing an exempt purpose of the organization solely because it is carried on as part of an activity described in clause (i), and

“(iii) insurance (other than commercial-type insurance, as defined in subsection (m)) for the activities described in clauses (i) and (ii).

“(C) MEDICALLY UNDERSERVED AREA.—The term ‘medically underserved area’ means, with respect to a health care service, any area reasonably determined by the organization (in a manner not inconsistent with regulations prescribed by the Secretary) to have—

“(i) a shortage (relative to the number of individuals needing such service) of health professionals performing such service, or

“(ii) a population group experiencing such a shortage.

Such term includes a health professional shortage area (as defined in section 332 of the Public Health Service Act).

“(D) INDEPENDENT MEMBER.—The term ‘independent member’ means a member of the board of directors of an organization who receives no compensation (directly or indirectly)—

“(i) for medical services performed in connection with such organization, or

“(ii) for services as an officer of such organization (other than as a member of such board).

For purposes of clause (ii), the term ‘officer’ includes any individual having powers or responsibilities similar to those of officers.

“(4) EXCEPTION.—This subsection shall not apply to any organization which provides health care services exclusively on an uncompensated basis, regardless of ability to pay.

“(5) SAFE HARBOR FOR NURSING HOMES.—

“(A) IN GENERAL.—A nursing home shall be treated as meeting the requirement of paragraph (1)(D) if it accepts a proportion of Medicaid patients which meets a safe harbor prescribed by the Secretary for purposes of this paragraph.

“(B) DEFINITIONS.—For purposes of subparagraph (A)—

“(i) NURSING HOME.—The term ‘nursing home’ means any facility which is of a type which is traditionally considered a nursing home.

“(ii) MEDICAID PATIENT.—The term ‘Medicaid patient’ means any individual eligible to receive medical assistance under a State plan approved under title XIX of the Social Security Act.

“(6) DISALLOWANCE OF CHARITABLE DEDUCTIONS.—No gift or bequest to an organization which is not exempt from tax by reason of this subsection shall be allowed as a deduction under section 170, 545(b)(2), 556(b)(2), 642(c), 2055, 2106(a)(2), or 2522.

“(7) REQUIREMENTS SUPPLEMENT OTHER REQUIREMENTS.—The requirements of this subsection are in addition to, and not in lieu of, the requirements otherwise applicable to an organization described in paragraph (3) or (4) of subsection (c).”

(b) REPORTING AND DISCLOSURE OF NEEDS ASSESSMENT AND PLAN.—

(1) REPORTING.—

(A) ORGANIZATIONS DESCRIBED IN SECTION 501(c)(3).—Subsection (b) of section 6033 (relating to certain organizations described in section 501(c)(3)) is amended by striking “and” at the end of paragraph (9), by redesignating paragraph (10) as paragraph (14), and by inserting after paragraph (9) the following new paragraphs:

“(10) in the case of an organization which prepares a plan described in section 501(n)(1)(A) (relating to community needs)—

“(A) a copy of such plan for the year, and

“(B) information on the implementation of such plan for the year (including unrecovered costs and revenues foregone in furtherance of such plan),

“(11)(A) the amount (if any) of tax paid by the organization during the year under section 4958 (relating to tax on failure to satisfy section 501(n)), and

“(B) the amount (if any) of tax imposed by section 4958 on the organization which was not assessed, or the assessment of which was abated, pursuant to section 4958(d),

“(12) such information as the Secretary may require with respect to any excess benefit transaction (as defined in section 4959(c)),

“(13) in the case of an applicable tax-exempt health care organization (as defined in section 4960), the respective amounts (if any) of the taxes paid by the organization during the year (and such other information as the Secretary may require with respect to the activities resulting in such taxes) under—

“(A) section 4911 (relating to tax on excess expenditures to influence legislation),

“(B) section 4912 (relating to tax on disqualifying lobbying expenditures of certain organizations), and

“(C) section 4955 (relating to taxes on political expenditures of section 501(c)(3) organizations), and”.

(B) ORGANIZATIONS DESCRIBED IN SECTION 501(c)(4).—Section 6033 is amended by redesignating subsection (f) as subsection (g) and by inserting after subsection (e) the following new subsection:

“(f) CERTAIN ORGANIZATIONS DESCRIBED IN SECTION 501(c)(4).—Every organization described in section 501(c)(4) which is subject to the requirements of subsection (a) and which prepares a plan described in section 501(n)(1)(A) (relating to community needs) for the year—

“(1) shall include a copy of such plan with the return required under subsection (a) for the year, and

"(2) shall include on such return the information referred to in paragraphs (10)(B), (11), and (12) of subsection (b) with respect to such organization."

(2) DISCLOSURE.—

(A) IN GENERAL.—Subsection (e) of section 6104 (relating to public inspection of certain annual returns and applications for exemption) is amended by adding at the end the following new paragraph:

"(3) COMMUNITY HEALTH CARE NEEDS ASSESSMENT AND PLAN AND APPLICATION FOR EXEMPTION.—

"(A) IN GENERAL.—Every organization which is required to prepare a plan described in section 501(n)(1)(A) (relating to community needs)—

"(i) shall make a copy of such plan (and the assessment on which such plan is based) available for inspection during regular business hours by any individual at the principal office of such organization and, if such organization regularly maintains 1 or more regional or district offices having 3 or more employees, at each such regional or district office, and

"(ii) upon request of an individual made at such principal office or such a regional or district office, shall provide—

"(I) a copy of such plan (and assessment),

"(II) a copy of the annual return filed under section 6033, and

"(III) a copy of the application, papers, letters, and other documents referred to in paragraph (2)(A)(ii),

to such individual without charge other than a reasonable fee for any reproduction and mailing costs.

If the request under clause (ii) is made in person, such copies shall be provided immediately and, if made other than in person, shall be provided within 30 days.

"(B) PERIOD OF AVAILABILITY.—Subparagraph (A) shall apply—

"(i) with respect to any plan (and assessment) during the 3-year period after the close of the year for which such plan is prepared,

"(ii) with respect to any return, during the 3-year period beginning on the filing date (as defined in paragraph (1)(D)), and

"(iii) with respect to the material referred to in subparagraph (A)(ii)(III), at any time.

"(C) LIMITATION.—Subparagraph (A)(ii) shall not apply to any request if the Secretary determines, upon application by an organization, that such request is part of a harassment campaign and that compliance with such request is not in the public interest."

(B) TECHNICAL AMENDMENT.—The heading for subsection (e) of section 6104 is amended by striking "AND APPLICATIONS FOR EXEMPTION" and inserting ", APPLICATIONS FOR EXEMPTION, AND COMMUNITY NEEDS ASSESSMENT AND PLAN FOR HEALTH AND OUTREACH SERVICES".

(c) FUNDRAISING SOLICITATIONS REQUIRED TO DISCLOSE AVAILABILITY OF ANNUAL RETURN.—

(1) Paragraph (1) of section 6104(e) is amended by adding at the end the following new subparagraph:

"(E) FUNDRAISING SOLICITATIONS OF CERTAIN HEALTH CARE ORGANIZATIONS REQUIRED TO DISCLOSE AVAILABILITY OF ANNUAL RETURN.—In the case of an applicable tax-exempt health care organization (as defined in section 4960), each fundraising solicitation (as defined in section 6113(c)) by (or on behalf of) such organization shall contain an express statement (in a conspicuous and easily recognizable format) that such return shall be provided to individuals upon request."

(2) PENALTY.—

(A) Section 6710 is amended by striking "section 6113" each place it appears and inserting "section 6113 or 6104(e)(1)(E)".

(B) Subsection (a) of section 6710 is amended by inserting "(\$100 in the case of a failure to meet the requirements of section 6104(e)(1)(E))" after "\$1,000".

(C) The section heading of section 6710 is amended by inserting before the period "; **FAILURE BY CERTAIN HEALTH CARE ORGANIZATIONS TO DISCLOSE AVAILABILITY OF ANNUAL RETURN**".

(D) The table of sections for part I of subchapter B of chapter 68 is amended by inserting before the period at the end of the item relating to section 6710 the following: "; Failure by Certain Health Care Organizations to Disclose Availability of Annual Return".

(E) Subparagraph (C) of section 6652(c)(1) is amended by striking "(e)(1)" and inserting "(e)(1) (other than subparagraph (E))".

(d) EFFECTIVE DATE.—

(1) **IN GENERAL.**—Except as provided in paragraphs (2) and (3), the amendments made by this section shall take effect on January 1, 1995.

(2) **REQUIREMENT OF INDEPENDENT BOARD OF DIRECTORS.**—Subparagraph (C) of section 501(n)(1) of the Internal Revenue Code of 1986, as added by this section, shall take effect on January 1, 1997.

(3) **HMO SERVICE REQUIREMENT.**—So much of the amendments made by this section as relate to section 501(n)(2) of such Code, as added by this section, shall take effect on the date of the enactment of this Act.

SEC. 11402. EXCISE TAXES FOR FAILURE BY TAX-EXEMPT HEALTH CARE ORGANIZATIONS TO MEET CERTAIN QUALIFICATION REQUIREMENTS.

(a) **IN GENERAL.**—Chapter 42 (relating to private foundations and certain other tax-exempt organizations) is amended by redesignating subchapter D as subchapter E and by inserting after subchapter C the following new subchapter:

“Subchapter D—Failure By Tax-Exempt Health Care Organizations To Meet Certain Qualification Requirements

“Sec. 4958. Tax on failure to satisfy section 501(n).

“Sec. 4959. Taxes on excess benefit transactions.

“Sec. 4960. Other definitions.

“SEC. 4958. TAX ON FAILURE TO SATISFY SECTION 501(n).

“(a) **IMPOSITION OF TAX.**—There is hereby imposed on any applicable tax-exempt health care organization which fails to meet 1 or more of the requirements of section 501(n)(1) during any taxable year a tax equal to the greater of—

“(1) \$25,000, or

“(2) 5 percent of the organization’s net investment income for such taxable year.

“(b) **PAYMENT OF TAX.**—The tax imposed by this section shall be paid by the organization.

“(c) **DETERMINATION OF NET INVESTMENT INCOME.**—For purposes of this section—

“(1) **IN GENERAL.**—The net investment income of an applicable tax-exempt health care organization shall include the net investment income of—

“(A) each organization which would be described in subparagraph (A) or (B) of section 509(a)(3) or in section 509(a)(4) with respect to such health care organization if such health care organization were described in section 509(a)(2), and

“(B) each organization which is organized and operated for the benefit of, and which directly or indirectly is controlled by, such health care organization.

“(2) **NET INVESTMENT INCOME.**—The term ‘net investment income’ has the meaning given such term by section 4940.

“(d) **WAIVER.**—If it is established to the satisfaction of the Secretary that—

“(1) a failure was due to reasonable cause and not to willful neglect, and

“(2) the organization has established safeguards to prevent future such failures (and has taken such additional corrective action as is prescribed by the Secretary by regulations),

then the tax imposed by subsection (a) (including interest) by reason of such failure shall not be assessed and, if assessed, the assessment shall be abated and, if collected, shall be credited or refunded as an overpayment.

“SEC. 4959. TAXES ON EXCESS BENEFIT TRANSACTIONS.

“(a) **INITIAL TAXES.**—

“(1) **ON THE DISQUALIFIED PERSON.**—There is hereby imposed on each excess benefit transaction a tax equal to 25 percent of the excess benefit. The tax imposed by this paragraph shall be paid by any disqualified person referred to in subsection (e)(1) with respect to such transaction.

“(2) **ON THE MANAGEMENT.**—In any case in which a tax is imposed by paragraph (1), there is hereby imposed on the participation of any organization manager in the excess benefit transaction, knowing that it is such a transaction, a tax equal to 10 percent of the excess benefit, unless such participation is not willful and is due to reasonable cause. The tax imposed by this paragraph shall be paid by any organization manager who participated in the excess benefit transaction.

"(b) **ADDITIONAL TAX ON THE DISQUALIFIED PERSON.**—In any case in which an initial tax is imposed by subsection (a)(1) on an excess benefit transaction and the excess benefit involved in such transaction is not corrected within the taxable period, there is hereby imposed a tax equal to 200 percent of the excess benefit involved. The tax imposed by this subsection shall be paid by any disqualified person referred to in subsection (e)(1) with respect to such transaction.

"(c) **EXCESS BENEFIT TRANSACTION; EXCESS BENEFIT.**—For purposes of this section—

"(1) **EXCESS BENEFIT TRANSACTION.**—

"(A) **IN GENERAL.**—The term 'excess benefit transaction' means any transaction in which an economic benefit is provided by an applicable tax-exempt health care organization to or for the use of any disqualified person if the value of the economic benefit provided exceeds the value of the consideration (including the performance of services) received for providing such benefit.

"(B) **LOANS AND CERTAIN PRIVATE INUREMENT INCLUDED.**—The term 'excess benefit transaction' includes—

"(i) any loan of money or other extension of credit by an applicable tax-exempt health care organization to or for the use of a disqualified person described in subsection (e)(1)(A)(i), and

"(ii) any transaction in which the amount of any economic benefit provided to or for the use of a disqualified person is determined in whole or in part by the gross or net revenues of 1 or more activities of the organization but only if such transaction results in inurement not permitted under paragraph (3) or (4) of section 501(c), as the case may be.

"(2) **EXCESS BENEFIT.**—

"(A) **IN GENERAL.**—Except as provided in subparagraph (B), the term 'excess benefit' means the excess referred to in paragraph (1)(A).

"(B) **LOANS AND PRIVATE INUREMENT INCLUDED.**—The term 'excess benefit' means—

"(i) in the case of a loan or extension of credit described in paragraph (1)(B)(i), the amount of the loan or the credit extended, and

"(ii) in the case of a transaction described in paragraph (1)(B)(ii), the amount of the inurement.

"(3) **EXCEPTION FOR ORGANIZATIONS SUBJECT TO PRIVATE FOUNDATION RULES.**—For purposes of this section, the term 'applicable tax-exempt health care organization' shall not include a private foundation (as defined in section 509(a)).

"(d) **SPECIAL RULES.**—For purposes of this section—

"(1) **JOINT AND SEVERAL LIABILITY.**—If more than 1 person is liable for any tax imposed by subsection (a) or subsection (b), all such persons shall be jointly and severally liable for such tax.

"(2) **LIMIT FOR MANAGEMENT.**—With respect to any 1 excess benefit transaction, the maximum amount of the tax imposed by subsection (a)(2) shall not exceed \$10,000.

"(e) **OTHER DEFINITIONS.**—For purposes of this section—

"(1) **DISQUALIFIED PERSON.**—The term 'disqualified person' means, with respect to any transaction—

"(A) any person who was, at any time during the 5-year period ending on the date of such transaction—

"(i) an organization manager, or

"(ii) an individual (other than an organization manager) in a position to exercise substantial influence over the affairs of the organization,

"(B) a member of the family of an individual described in subparagraph (A), and

"(C) a 35-percent controlled entity.

"(2) **ORGANIZATION MANAGER.**—The term 'organization manager' means, with respect to any applicable tax-exempt health care organization, any officer, director, or trustee of such organization (or any individual having powers or responsibilities similar to those of officers, directors, or trustees of the organization).

"(3) **35-PERCENT CONTROLLED ENTITY.**—

"(A) **IN GENERAL.**—The term '35-percent controlled entity' means—

"(i) a corporation in which persons described in subparagraph (A) or (B) of paragraph (1) own more than 35 percent of the total combined voting power,

"(ii) a partnership in which such persons own more than 35 percent of the profits interest, and

"(iii) a trust or estate in which such persons own more than 35 percent of the beneficial interest.

"(B) CONSTRUCTIVE OWNERSHIP RULES.—Rules similar to the rules of paragraphs (3) and (4) of section 4946(a) shall apply for purposes of this paragraph.

"(4) FAMILY MEMBERS.—The members of an individual's family shall be determined under section 4946(d); except that such members also shall include the brothers and sisters (whether by the whole or half blood) of the individual and their spouses.

"(f) TREATMENT OF PREVIOUSLY EXEMPT ORGANIZATIONS.—

"(1) IN GENERAL.—For purposes of this section, the status of any organization as an applicable tax-exempt health care organization shall be terminated only if—

"(A)(i) such organization notifies the Secretary (at such time and in such manner as the Secretary may by regulations prescribe) of its intent to accomplish such termination, or

"(ii) there is a final determination by the Secretary that such status has terminated, and

"(B)(i) such organization pays the tax imposed by paragraph (2) (or any portion not abated pursuant to paragraph (3)), or

"(ii) the entire amount of such tax is abated pursuant to paragraph (3).

"(2) IMPOSITION OF TAX.—There is hereby imposed on each organization referred to in paragraph (1) a tax equal to the lesser of—

"(A) the amount which the organization substantiates by adequate records or other corroborating evidence as the aggregate tax benefit resulting from its exemption from tax under section 501(a), or

"(B) the value of the net assets of such organization.

"(3) ABATEMENT OF TAX.—The Secretary may abate the unpaid portion of the assessment of any tax imposed by paragraph (2), or any liability in respect thereof, if the applicable tax-exempt health care organization distributes all of its net assets to 1 or more organizations each of which has been in existence, and described in section 501(c)(3), for a continuous period of at least 60 calendar months. If the distributing organization is described in section 501(c)(4), the preceding sentence shall be applied by treating the reference to section 501(c)(3) as including a reference to section 501(c)(4).

"(4) CERTAIN RULES MADE APPLICABLE.—Rules similar to the rules of subsections (d), (e), and (f) of section 507 shall apply for purposes of this subsection.

"SEC. 4960. OTHER DEFINITIONS.

"(a) APPLICABLE TAX-EXEMPT HEALTH CARE ORGANIZATION.—For purposes of this subchapter, the term 'applicable tax-exempt health care organization' means any organization—

"(1) the predominant activity of which is the provision of health care services (as defined in section 501(n)(3)), and

"(2) which (without regard to any failure to meet any requirement of section 501(n) or any excess benefit) would be described in paragraph (3) or (4) of section 501(c) and exempt from tax under section 501(a).

"(b) TAXABLE PERIOD; CORRECTION.—For purposes of this subchapter—

"(1) TAXABLE PERIOD.—The term 'taxable period' means, with respect to any excess benefit transaction, the period beginning with the date on which the transaction occurs and ending on the earliest of—

"(A) the date of mailing a notice of deficiency under section 6212 with respect to the tax imposed by subsection (a)(1) of section 4959, or

"(B) the date on which the tax imposed by such subsection (a)(1) is assessed.

"(2) CORRECTION.—The terms 'correction' and 'correct' mean, with respect to any excess benefit transaction, undoing the excess benefit to the extent possible, establishing safeguards to prevent future such excess benefit, and where fully undoing the excess benefit is not possible, such additional corrective action as is prescribed by the Secretary by regulations."

(b) APPLICATION OF PRIVATE INUREMENT RULE TO TAX-EXEMPT HEALTH CARE ORGANIZATIONS DESCRIBED IN SECTION 501(c)(4).—Paragraph (4) of section 501(c) is amended by inserting "(A)" after "(4)" and by adding at the end the following:

"(B) Subparagraph (A) shall not apply to an entity the predominant activity of which is the provision of health care services (as defined in subsection (n)(3)) unless no part of the net earnings of such entity inures to the benefit of any private shareholder or individual."

(c) TECHNICAL AND CONFORMING AMENDMENTS.—

(1) Subsection (e) of section 4955 is amended—

(A) by striking “SECTION 4945” in the heading and inserting “SECTIONS 4945 and 4959”, and

(B) by inserting before the period “or an excess benefit for purposes of section 4959”.

(2) Subsections (a), (b), and (c) of section 4963 are each amended by inserting “4959,” after “4955”.

(3) Subsection (e) of section 6213 is amended by inserting “4959 (relating to private excess benefit),” before “4971”.

(4) Paragraphs (2) and (3) of section 7422(g) are each amended by inserting “4959,” after “4955”.

(5) Subsection (b) of section 7454 is amended by inserting “or whether an organization manager (as defined in section 4959(e)(2)) has ‘knowingly’ participated in an excess benefit transaction (as defined in section 4959(c)),” after “section 4912(b),”.

(6) The table of subchapters for chapter 42 is amended by striking the last item and inserting the following:

“Subchapter D. Failure by tax-exempt health care organizations to meet certain qualification requirements.

“Subchapter E. Abatement of first and second tier taxes in certain cases.”

(d) EFFECTIVE DATES.—

(1) SECTION 501(n) REQUIREMENTS.—The amendments made by this section, to the extent related to section 4958 of the Internal Revenue Code of 1986 (as added by this section), shall take effect on January 1, 1995.

(2) EXCESS BENEFIT TRANSACTION RULES.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the amendments made by this section, to the extent related to section 4959 of such Code (as added by this section), shall apply to excess benefit transactions occurring on or after June 30, 1994.

(B) BINDING CONTRACTS FOR PERSONAL SERVICES.—The amendments referred to in subparagraph (A) shall not apply to any transaction pursuant to any written contract for the performance of personal services which was binding on June 29, 1994, and at all times thereafter before such transaction occurred.

(3) APPLICATION OF PRIVATE INUREMENT RULE TO TAX-EXEMPT HEALTH CARE ORGANIZATIONS DESCRIBED IN SECTION 501(c)(4).—

(A) IN GENERAL.—The amendment made by subsection (b) shall apply to inurement occurring on or after June 30, 1994.

(B) BINDING CONTRACTS.—The amendment made by subsection (b) shall not apply to any inurement occurring before July 1, 1996, pursuant to a written contract which was binding on June 29, 1994, and at all times thereafter before such inurement occurred.

SEC. 11403. TREATMENT OF NONPROFIT HEALTH CARE ORGANIZATIONS.

(a) INSURANCE PROVIDED BY HEALTH MAINTENANCE ORGANIZATIONS.—Section 501(m) (relating to certain organizations providing commercial-type insurance not exempt from tax) is amended by adding at the end the following new paragraph:

“(6) CERTAIN ACTIVITIES PROVIDED BY HEALTH MAINTENANCE ORGANIZATIONS NOT TREATED AS COMMERCIAL-TYPE INSURANCE.—For purposes of this subsection, the provision of (or the arranging for the provision of) medical care on a prepaid basis by a health maintenance organization shall not be treated as commercial-type insurance if (and only if) such care is—

“(A) care provided by such organization to its members at its own facilities through health care professionals who do not provide substantial health care services other than on behalf of such organization,

“(B) care provided by a health care professional to a member of such organization on a basis under which substantially all of the risks of the rates of utilization is assumed by the provider of such care,

“(C) care (other than primary care) provided to a member of such organization pursuant to a referral by such organization,

“(D) emergency care provided to a member of such organization at a location outside such member’s area of residence, or

“(E) care which the organization reasonably expected to be provided to a member as described in subparagraph (A), (B), or (C) but which was not so provided pursuant to section 2219(d) of the Social Security Act.”

(2) TECHNICAL AMENDMENTS.—

(A) Paragraph (3) of section 501(m) is amended by striking subparagraph (B) and by redesignating subparagraphs (C), (D), and (E) as subparagraphs (B), (C), and (D), respectively.

(B) Paragraph (5) of section 501(m) is amended by striking "paragraph (3)(E)" and inserting "paragraph (3)(D)".

(b) TREATMENT OF PARENT ORGANIZATIONS OF HEALTH CARE PROVIDERS.—Section 509(a) (defining private foundation) is amended by striking "and" at the end of paragraph (3), by redesignating paragraph (4) as paragraph (5), and by inserting after paragraph (3) the following new paragraph:

"(4) an organization which is organized and operated for the benefit of, and which directly or indirectly controls, an organization described in section 170(b)(1)(A)(iii); and".

(c) REGIONAL ALLIANCES EXEMPT FROM TAX.—

(1) IN GENERAL.—Subsection (c) of section 501 (relating to exemption from tax on corporations, certain trusts, etc.) is amended by adding at the end the following new paragraph:

"(26)(A) Any regional alliance described in subtitle E of title V of the Health Security Act.

"(B) Such an alliance shall not be exempt from tax pursuant to any provision other than this paragraph.

"(C) Such an alliance shall not be exempt from tax unless—

"(i) no part of the net earnings of such alliance inures to the benefit of any private shareholder or individual,

"(ii) no substantial part of the activities of such alliance is carrying on propaganda, or otherwise attempting, to influence legislation (except as otherwise provided in subsection (h)), and

"(iii) such alliance does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office."

(2) CERTAIN PROVISIONS APPLICABLE TO ORGANIZATIONS DESCRIBED IN SECTION 501(C)(3) MADE APPLICABLE TO REGIONAL ALLIANCES.—Section 501 is amended by redesignating subsection (o) as subsection (p) and by inserting after subsection (n) the following new subsection:

"(o) CERTAIN PROVISIONS MADE APPLICABLE TO REGIONAL ALLIANCES.—A regional alliance described in subsection (c)(26) shall be treated—

"(1) as described in subsection (c)(3) for purposes of applying subsection (h) (relating to expenditures by public charities to influence legislation), section 4955 (relating to taxes on political expenditures of section 501(c)(3) organizations), and section 4959 (relating to private inurement), and

"(2) as described in subsection (h)(4)."

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

SEC. 11404. TAX TREATMENT OF TAXABLE ORGANIZATIONS PROVIDING HEALTH INSURANCE AND OTHER PREPAID HEALTH CARE SERVICES.

(a) GENERAL RULE.—Section 831 is amended by redesignating subsection (c) as subsection (d) and by inserting after subsection (b) the following new subsection:

"(c) TREATMENT OF ORGANIZATIONS PROVIDING HEALTH INSURANCE AND OTHER PREPAID HEALTH CARE SERVICES.—

"(1) GENERAL RULE.—Any organization to which this subsection applies shall be taxable under this part in the same manner as if it were an insurance company other than a life insurance company.

"(2) ORGANIZATIONS TO WHICH SUBSECTION APPLIES.—This subsection shall apply to any organization—

"(A) which is not exempt from taxation under this subtitle,

"(B) which is not taxable as a life insurance company under part I of this subchapter,

"(C) which is not an organization to which section 833 applies, and

"(D) the primary and predominant business activity of which during the taxable year consists of 1 or more of the following:

"(i) Issuing accident and health insurance contracts or the reinsuring of risks undertaken by other insurance companies under such contracts.

"(ii) Operating as a health maintenance organization.

"(iii) Entering into arrangements under which—

"(I) fixed payments or premiums are received as consideration for the organization's agreement to provide or arrange for the provi-

sion of health care services, regardless of how the health care services are provided or arranged to be provided, and

“(II) substantially all of the risks of the rates of utilization of such services is assumed by the provider of such services.

In the case of an organization which has as a material business activity the issuing of accident and health insurance contracts or the reinsuring of risks undertaken by other insurance companies under such contracts, the administering of accident and health insurance contracts by such organization shall be treated as part of such business activity for purposes of subparagraph (D)(i).”

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by this section shall apply to taxable years beginning after December 31, 1994.

(2) TRANSITIONAL RULES.—

(A) ORGANIZATIONS TO WHICH PARAGRAPH APPLIES.—This paragraph shall apply to any organization to which section 831(c) of the Internal Revenue Code of 1986 (as added by subsection (a)) applies for such organization's first taxable year beginning after December 31, 1994; except that this paragraph shall not apply if—

(i) such organization treated itself as an insurance company taxable under part II of subchapter L of chapter 1 of such Code on its original Federal income tax return for its taxable year beginning in 1992 and for all of its taxable years thereafter beginning before January 1, 1995, or

(ii) such organization was exempt from tax under chapter 1 of such Code for such organization's last taxable year beginning before January 1, 1995.

(B) TREATMENT OF CURRENTLY TAXABLE COMPANIES.—In the case of any organization to which this paragraph applies—

(i) the amendments made by this section shall be treated as a change in the method of accounting, and

(ii) all adjustments required to be taken into account under section 481 of the Internal Revenue Code of 1986 shall be taken into account for such company's first taxable year beginning after December 31, 1994.

SEC. 11405. ORGANIZATIONS SUBJECT TO SECTION 833.

(a) IN GENERAL.—Section 833(c) (relating to organization to which section applies) is amended by adding at the end the following new paragraph:

“(4) TREATMENT AS EXISTING BLUE CROSS OR BLUE SHIELD ORGANIZATION.—

“(A) IN GENERAL.—Paragraph (2) shall be applied to an organization described in subparagraph (B) as if it were a Blue Cross or Blue Shield organization.

“(B) APPLICABLE ORGANIZATION.—An organization is described in this subparagraph if it—

“(i) is organized under, and governed by, State laws which are specifically and exclusively applicable to not-for-profit health insurance or health-service type organizations, and

“(ii) is not a Blue Cross or Blue Shield organization or health maintenance organization.”

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 1986.

SEC. 11406. TAX EXEMPTION FOR HIGH-RISK INSURANCE POOLS.

(a) IN GENERAL.—Subsection (c) of section 501 (relating to list of exempt organizations) is amended by adding at the end the following new paragraph:

“(27) In the case of taxable years beginning before January 1, 1998, any corporation, association, or similar legal entity which is created by any State or political subdivision thereof to establish a risk pool to provide health insurance coverage to any person unable to obtain health insurance coverage in the private insurance market because of health conditions and no part of the net earnings of which inures to the benefit of any private shareholder, member, or individual.”

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 1989.

Subtitle E—Treatment of Accelerated Death Benefits Under Life Insurance Contracts

SEC. 11501. TAX TREATMENT OF ACCELERATED DEATH BENEFITS UNDER LIFE INSURANCE CONTRACTS.

(a) GENERAL RULE.—Section 101 (relating to certain death benefits) is amended by adding at the end the following new subsection:

“(g) TREATMENT OF CERTAIN ACCELERATED DEATH BENEFITS.—

“(1) IN GENERAL.—For purposes of this section, any amount received under a life insurance contract on the life of an insured who is a terminally ill individual shall be treated as an amount paid by reason of the death of such insured.

“(2) NECESSARY CONDITIONS.—

“(A) IN GENERAL.—Paragraph (1) shall not apply to any amount received unless—

“(i) the total amount received is not less than the present value (determined under subparagraph (B)) of the reduction in the death benefit otherwise payable in the event of the death of the insured, and

“(ii) the percentage reduction by reason of the distribution in the cash surrender value of the contract does not exceed the percentage reduction by reason of such distribution in the death benefit payable under the contract.

For purposes of this subparagraph, any amount referred to in paragraph (1) that is received as a loan or lien shall be treated as a reduction, at the time of receipt, in the death benefit or the cash surrender value to the extent that the death benefit or cash surrender value, respectively, are encumbered (or can become encumbered) by the amount of such loan or lien (or amounts related thereto).

“(B) DETERMINATION OF PRESENT VALUE.—The present value of a reduction in the death benefit shall be determined by—

“(i) using a discount rate not to exceed the highest rate set forth in subparagraph (C), and

“(ii) assuming that the death benefit (or the portion thereof) would have been paid on the date which is 12 months after the date of the certification referred to in paragraph (3).

“(C) RATES.—The rates set forth in this subparagraph are the following:

“(i) the 90-day Treasury bill yield,

“(ii) the rate described as Moody's Corporate Bond Yield Average-Monthly Average Corporates, as published by Moody's Investors Service, Inc., or any successor thereto, for the calendar month ending 2 months before the date on which the rate is determined, and

“(iii) the rate used to compute the cash surrender values under the contract during the applicable period plus 1 percent per annum.

“(D) LIENS.—To the extent a lien is imposed against the death benefit in connection with the distribution, the rate of any interest charged may not exceed the highest rate set forth in subparagraph (C), and such lien may not encumber the cash surrender value such that the percentage amount of the cash surrender value that is encumbered exceeds the percentage amount of the death benefit that is encumbered.

“(3) TERMINALLY ILL INDIVIDUAL.—For purposes of this subsection, the term ‘terminally ill individual’ means an individual who the insurer has determined, after receipt of an acceptable certification by a licensed physician, has an illness or physical condition which is reasonably expected to result in death within 12 months after the date of certification.

“(4) EXCEPTION FOR BUSINESS-RELATED POLICIES.—This subsection shall not apply in the case of any amount paid to any taxpayer other than the insured if such taxpayer has an insurable interest with respect to the life of the insured by reason of the insured being a director, officer, or employee of the taxpayer or by reason of the insured being financially interested in any trade or business carried on by the taxpayer.”

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendment made by subsection (a) shall apply to amounts received after the date of the enactment of this Act.

(2) DELAY IN APPLICATION OF DISCOUNTING RULES.—Clause (i) of section 101(g)(2)(A) of the Internal Revenue Code of 1986 (as added by this section) shall not apply to any amount received before January 1, 1995.

(3) **ISSUANCE OF RIDER NOT TREATED AS MATERIAL CHANGE.**—For purposes of applying sections 101(f), 7702, and 7702A of the Internal Revenue Code of 1986 to any contract, the issuance of a qualified accelerated death benefit rider (as defined in section 818(g) of such Code (as added by this Act)) shall not be treated as a modification or material change of such contract.

SEC. 11502. TAX TREATMENT OF COMPANIES ISSUING QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.

(a) **QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.**—Section 818 (relating to other definitions and special rules) is amended by adding at the end the following new subsection:

“(g) **QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.**—For purposes of this part—

“(1) **IN GENERAL.**—Any reference to a life insurance contract shall be treated as including a reference to a qualified accelerated death benefit rider on such contract.

“(2) **QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.**—For purposes of this subsection, the term ‘qualified accelerated death benefit rider’ means any rider on a life insurance contract if the only payments under the rider are payments meeting the requirements of section 101(g).”

(c) **EFFECTIVE DATE.**—The amendments made by this section shall take effect on January 1, 1995.

Subtitle F—Employment Status Provisions

SEC. 11601. EMPLOYMENT STATUS PROPOSAL REQUIRED FROM DEPARTMENT OF THE TREASURY.

Not later than January 1, 1996, the Secretary of the Treasury shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a legislative proposal relating to the classification of workers as employees or independent contractors.

SEC. 11602. INCREASE IN PENALTIES RELATING TO REPORTING OF PAYMENTS FOR SERVICES.

(a) **INCREASE IN PENALTY.**—Section 6721(a) (relating to imposition of penalty) is amended by adding at the end the following new paragraph:

“(3) **INCREASED PENALTY FOR RETURNS INVOLVING PAYMENTS FOR SERVICES.**—

“(A) **IN GENERAL.**—Subject to the overall limitation of paragraph (1), the amount of the penalty under paragraph (1) for any failure with respect to any applicable return shall be equal to the greater of \$50 or 5 percent of the amount required to be reported correctly but not so reported.

“(B) **EXCEPTION WHERE SUBSTANTIAL COMPLIANCE.**—Subparagraph (A) shall not apply to failures with respect to applicable returns required to be filed by a person during any calendar year if the aggregate amount which is timely and correctly reported on applicable returns filed by the person for the calendar year is at least 97 percent of the aggregate amount which is required to be reported on applicable returns by the person for the calendar year.

“(C) **APPLICABLE RETURN.**—For purposes of this paragraph, the term ‘applicable return’ means any information return required to be filed under—

“(i) section 6041(a) but only if such return relates to payments to any person for services performed by such person (other than as an employee), or

“(ii) section 6041A(a).”

(b) **CONFORMING AMENDMENT.**—Section 6721(a)(1) is amended by striking “In” and inserting “Except as provided in paragraph (3), in”.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply to returns the due date for which (without regard to extensions) is more than 30 days after the date of the enactment of this Act.

Subtitle G—Tax Treatment of Funding of Retiree Health Benefits

SEC. 11701. POST-RETIREMENT MEDICAL AND LIFE INSURANCE RESERVES.

(a) **MINIMUM PERIOD FOR WORKING LIVES.**—Section 419A(c)(2) (relating to additional reserve for post-retirement medical and life insurance benefits) is amended by inserting “(but not less than 10 years)” after “working lives of the covered employees”.

(b) **SEPARATE ACCOUNTING.**—

(1) **REQUIREMENT.**—Section 419A(c)(2) is amended by adding at the end the following new flush sentence:
“Such reserve shall be maintained as a separate account.”

(2) **USE OF RESERVE FOR OTHER PURPOSES.**—Paragraph (1) of section 4976(b) (defining disqualified benefit) is amended by striking “and” at the end of subparagraph (B), by striking the period at the end of subparagraph (C) and inserting “, and”, and by adding after subparagraph (C) the following new subparagraph:

“(D) any payment to which subparagraph (C) does not apply which is out of an account described in section 419A(c)(2) and which is not used to provide a post-retirement medical benefit or life insurance benefit.”

(c) **EFFECTIVE DATES.**—

(1) **IN GENERAL.**—Except as provided in paragraph (2), the amendments made by this section shall apply to contributions paid or accrued after December 31, 1994, in taxable years ending after such date.

(2) **SEPARATE ACCOUNTING.**—The amendments made by subsection (b) shall apply to contributions paid or accrued after the date of the enactment of this Act, in taxable years ending after such date.

Subtitle H—Excise Taxes on Insured and Self-Insured Health Plans

SEC. 11801. EXCISE TAXES ON INSURED AND SELF-INSURED HEALTH PLANS.

(a) **GENERAL RULE.**—Chapter 34 is amended by adding at the end the following new subchapter:

“Subchapter B—Insured and Self-Insured Health Plans

“Sec. 4375. Health insurance and health-related administrative services.

“Sec. 4376. Self-insured health plans.

“Sec. 4377. Definitions and special rules.

“SEC. 4375. HEALTH INSURANCE AND HEALTH-RELATED ADMINISTRATIVE SERVICES.

“(a) **IMPOSITION OF TAX.**—There is hereby imposed—

“(1) on each taxable health insurance policy, a tax equal to 2 percent of the premiums received under such policy, and

“(2) on each amount received for health-related administrative services, a tax equal to 2 percent of the amount so received.

“(b) **LIABILITY FOR TAX.**—

“(1) **HEALTH INSURANCE.**—The tax imposed by subsection (a)(1) shall be paid by the issuer of the policy.

“(2) **HEALTH-RELATED ADMINISTRATIVE SERVICES.**—The tax imposed by subsection (a)(2) shall be paid by the person providing the health-related administrative services.

“(c) **TAXABLE HEALTH INSURANCE POLICY.**—For purposes of this section—

“(1) **IN GENERAL.**—Except as otherwise provided in this section, the term ‘taxable health insurance policy’ means any accident or health insurance policy issued with respect to individuals residing in the United States.

“(2) **EXEMPTION OF CERTAIN POLICIES.**—The term ‘taxable health insurance policy’ does not include any insurance policy if substantially all of the coverage provided under such policy relates to—

“(A) liabilities incurred under workers’ compensation laws,

“(B) tort liabilities,

“(C) liabilities relating to ownership or use of property,

“(D) credit insurance, or

"(E) such other similar liabilities as the Secretary may specify by regulations.

"(3) SPECIAL RULE WHERE POLICY PROVIDES OTHER COVERAGE.—In the case of any taxable health insurance policy under which amounts are payable other than for accident and health coverage, in determining the amount of the tax imposed by subsection (a)(1) on any premium received under such policy, there shall be excluded the amount of the charge for the non-accident and health coverage if—

"(A) the charge for such non-accident and health coverage is either separately stated in the policy, or furnished to the policyholder in a separate statement, and

"(B) such charge is reasonable in relation to the total charges under the policy.

In any other case, the entire amount of the premium received under such a policy shall be subject to tax under subsection (a)(1).

"(4) TREATMENT OF PREPAID HEALTH COVERAGE ARRANGEMENTS.—

"(A) IN GENERAL.—In the case of any arrangement described in subparagraph (B)—

"(i) such arrangement shall be treated as a taxable health insurance policy,

"(ii) the payments or premiums referred to in subparagraph (B)(i) shall be treated as premiums received for a taxable health insurance policy, and

"(iii) the person referred to in subparagraph (B)(i) shall be treated as the issuer.

"(B) DESCRIPTION OF ARRANGEMENTS.—An arrangement is described in this subparagraph if under such arrangement—

"(i) fixed payments or premiums are received as consideration for any person's agreement to provide or arrange for the provision of accident or health coverage to residents of the United States, regardless of how such coverage is provided or arranged to be provided, and

"(ii) substantially all of the risks of the rates of utilization of services is assumed by such person or the provider of such services.

"(d) HEALTH-RELATED ADMINISTRATIVE SERVICES.—For purposes of this section, the term 'health-related administrative services' means—

"(1) the processing of claims or performance of other administrative services in connection with accident or health coverage under a taxable health insurance policy if the charge for such services is not included in the premiums under such policy, and

"(2) processing claims, arranging for provision of accident or health coverage, or performing other administrative services in connection with an applicable self-insured health plan (as defined in section 4376(c)) established or maintained by another person.

"SEC. 4376. SELF-INSURED HEALTH PLANS.

"(a) IMPOSITION OF TAX.—In the case of any applicable self-insured health plan, there is hereby imposed a tax for each month equal to 2 percent of the sum of—

"(1) the accident and health coverage expenditures for such month under such plan, and

"(2) the direct administrative expenditures for such month under such plan.

"(b) LIABILITY FOR TAX.—

"(1) IN GENERAL.—The tax imposed by subsection (a) shall be paid by the plan sponsor.

"(2) PLAN SPONSOR.—For purposes of paragraph (1) the term 'plan sponsor' means—

"(A) the employer in the case of a plan established or maintained by a single employer,

"(B) the employee organization in the case of a plan established or maintained by an employee organization,

"(C) in the case of—

"(i) a plan established or maintained by 2 or more employers or jointly by 1 or more employers and 1 or more employee organizations,

"(ii) a multiple employer welfare arrangement, or

"(iii) a voluntary employees' beneficiary association described in section 501(c)(9),

the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan, or

“(D) the cooperative or association described in subsection (c)(2)(F) in the case of a plan established or maintained by such a cooperative or association.

“(c) **APPLICABLE SELF-INSURED HEALTH PLAN.**—For purposes of this section, the term ‘applicable self-insured health plan’ means any plan for providing accident or health coverage if—

“(1) any portion of such coverage is provided other than through an insurance policy, and

“(2) such plan is established or maintained—

“(A) by one or more employers for the benefit of their employees or former employees,

“(B) by one or more employee organizations for the benefit of their members or former members,

“(C) jointly by 1 or more employers and 1 or more employee organizations for the benefit of employees or former employees,

“(D) by a voluntary employees’ beneficiary association described in section 501(c)(9),

“(E) by any organization described in section 501(c)(6), or

“(F) in the case of a plan not described in the preceding subparagraphs, by a multiple employer welfare arrangement (as defined in section 3(40) of Employee Retirement Income Security Act of 1974), a rural electric cooperative (as defined in section 3(40)(B)(iv) of such Act), or a rural telephone cooperative association (as defined in section 3(40)(B)(v) of such Act).

“(d) **ACCIDENT AND HEALTH COVERAGE EXPENDITURES.**—For purposes of this section—

“(1) **IN GENERAL.**—The accident and health coverage expenditures of any applicable self-insured health plan for any month is the aggregate expenditures for such month for accident and health coverage provided under such plan to the extent such expenditures are not subject to tax under section 4375.

“(2) **TREATMENT OF REIMBURSEMENTS.**—In determining accident and health coverage expenditures during any month of any applicable self-insured health plan, reimbursements (by insurance or otherwise) received during such month for accident and health coverage expenditures shall be taken into account as a reduction in accident and health coverage expenditures.

“(3) **CERTAIN EXPENDITURES DISREGARDED.**—Paragraph (1) shall not apply to any expenditure for the acquisition or improvement of land or for the acquisition or improvement of any property to be used in connection with the provision of accident and health coverage which is subject to the allowance under section 167, except that, for purposes of paragraph (1), allowances under section 167 shall be considered as expenditures.

“(e) **DIRECT ADMINISTRATIVE EXPENDITURES.**—For purposes of this section, the term ‘direct administrative expenditures’ means the administrative expenditures under the plan to the extent such expenditures are not subject to tax under section 4375. In determining the amount of such expenditures, rules similar to the rules of subsection (d)(3) shall apply.

“SEC. 4377. DEFINITIONS AND SPECIAL RULES.

“(a) **DEFINITIONS.**—For purposes of this subchapter—

“(1) **ACCIDENT AND HEALTH COVERAGE.**—The term ‘accident and health coverage’ means any coverage which, if provided by an insurance policy, would cause such policy to be a taxable health insurance policy (as defined in section 4375(c).

“(2) **INSURANCE POLICY.**—The term ‘insurance policy’ means any policy or other instrument whereby a contract of insurance is issued, renewed, or extended.

“(3) **PREMIUM.**—The term ‘premium’ means the gross amount of premiums and other consideration (including advance premiums, deposits, fees, and assessments) arising from policies issued by a person acting as the primary insurer, adjusted for any return or additional premiums paid as a result of endorsements, cancellations, audits, or retrospective rating.

“(4) **UNITED STATES.**—The term ‘United States’ includes any possession of the United States.

“(b) **TREATMENT OF GOVERNMENTAL ENTITIES.**—

“(1) **IN GENERAL.**—For purposes of this subchapter—

“(A) the term ‘person’ includes any governmental entity, and

“(B) notwithstanding any other law or rule of law, governmental entities shall not be exempt from the taxes imposed by this subchapter except as provided in paragraph (2).

“(2) TREATMENT OF EXEMPT GOVERNMENTAL PROGRAMS.—In the case of an exempt governmental program—

“(A) no tax shall be imposed under section 4375 on any premium received pursuant to such program or on any amount received for health-related administrative services pursuant to such program, and

“(B) no tax shall be imposed under section 4376 on any expenditures pursuant to such program.

“(3) EXEMPT GOVERNMENTAL PROGRAM DEFINED.—For purposes of this subchapter, the term ‘exempt governmental program’ means—

“(A) the insurance programs established by parts A and B of title⁸ XVIII of the Social Security Act,

“(B) medicare part C (as defined in section 3467),

“(C) the medical assistance program established by title XIX of the Social Security Act,

“(D) any program established by Federal law for providing medical care (other than through insurance policies) to individuals (or the spouses and dependents thereof) by reason of such individuals being—

“(i) members of the Armed Forces of the United States, or

“(ii) veterans, and

“(E) any program established by Federal law for providing medical care (other than through insurance policies) to members of Indian tribes (as defined in section 4(d) of the Indian Health Care Improvement Act).

“(c) NO COVER OVER TO POSSESSIONS.—Notwithstanding any other provision of law, no amount collected under this subchapter shall be covered over to any possession of the United States.”

(b) CLERICAL AMENDMENT.—Chapter 34 is amended by striking the chapter heading and inserting the following:

“CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES

“Subchapter A. Policies issued by foreign insurers.

“Subchapter B. Insured and self-insured health plans.

“Subchapter A—Policies Issued By Foreign Insurers”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to premiums received and expenses incurred after December 31, 1995.

Subtitle I—Other Provisions

PART 1—TAX INCENTIVES FOR HEALTH SERVICES PROVIDERS

SEC. 11901. NONREFUNDABLE CREDIT FOR CERTAIN PRIMARY HEALTH SERVICES PROVIDERS.

(a) IN GENERAL.—Subpart A of part IV of subchapter A of chapter 1 (relating to nonrefundable personal credits) is amended by inserting after section 22 the following new section:

“SEC. 23. PRIMARY HEALTH SERVICES PROVIDERS.

“(a) ALLOWANCE OF CREDIT.—There shall be allowed as a credit against the tax imposed by this chapter for the taxable year an amount equal to the product of—

“(1) the number of months during such taxable year—

“(A) during which the taxpayer is a qualified primary health services provider, and

“(B) which are within the taxpayer’s mandatory service period, and

“(2) \$1,000 (\$500 in the case of a qualified practitioner who is not a physician).

“(b) QUALIFIED PRIMARY HEALTH SERVICES PROVIDER.—For purposes of this section, the term ‘qualified primary health services provider’ means, with respect to any month, any qualified practitioner who—

“(1) has in effect a certification by the Bureau as a provider of primary health services and such certification is, when issued, for a health professional shortage area in which the qualified practitioner is commencing the providing of primary health services,

"(2) is providing primary health services full time in the health professional shortage area identified in such certification, and

"(3) has not received a scholarship under the National Health Service Corps Scholarship Program or any loan repayments under the National Health Service Corps Loan Repayment Program.

For purposes of paragraph (2) and subsection (e)(3), a provider shall be treated as providing services in a health professional shortage area when such area ceases to be such an area if it was such an area when the provider commenced providing services in the area.

"(c) MANDATORY SERVICE PERIOD.—For purposes of this section, the term 'mandatory service period' means the period of 60 consecutive calendar months beginning with the first month the taxpayer is a qualified primary health services provider. A taxpayer shall not have more than 1 mandatory service period.

"(d) DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

"(1) BUREAU.—The term 'Bureau' means the Bureau of Primary Health Care, Health Resources and Services Administration of the United States Public Health Service.

"(2) QUALIFIED PRACTITIONER.—The term 'qualified practitioner' means a physician, a physician assistant, a nurse practitioner, or a certified nurse-midwife.

"(3) PHYSICIAN.—The term 'physician' has the meaning given to such term by section 1861(r) of the Social Security Act.

"(4) PHYSICIAN ASSISTANT; NURSE PRACTITIONER.—The terms 'physician assistant' and 'nurse practitioner' have the meanings given to such terms by section 1861(aa)(5) of the Social Security Act.

"(5) CERTIFIED NURSE-MIDWIFE.—The term 'certified nurse-midwife' has the meaning given to such term by section 1861(gg)(2) of the Social Security Act.

"(6) PRIMARY HEALTH SERVICES.—The term 'primary health services' has the meaning given such term by section 330(b)(1) of the Public Health Service Act.

"(7) HEALTH PROFESSIONAL SHORTAGE AREA.—The term 'health professional shortage area' has the meaning given such term by section 332(a)(1)(A) of the Public Health Service Act.

"(e) RECAPTURE OF CREDIT.—

"(1) IN GENERAL.—If there is a recapture event during any taxable year, then—

"(A) no credit shall be allowed under subsection (a) for such taxable year and any succeeding taxable year, and

"(B) the tax of the taxpayer under this chapter for such taxable year shall be increased by an amount equal to the product of—

"(i) the applicable percentage, and

"(ii) the aggregate unrecaptured credits allowed to such taxpayer under this section for all prior taxable years.

"(2) APPLICABLE RECAPTURE PERCENTAGE.—

"(A) IN GENERAL.—For purposes of this subsection, the applicable recapture percentage shall be determined from the following table:

"If the recapture event occurs during:	The applicable recapture percentage is:
Months 1–24	100
Months 25–36	75
Months 37–48	50
Months 49–60	25
Month 61 or thereafter	0.

"(B) TIMING.—For purposes of subparagraph (A), month 1 shall begin on the first day of the mandatory service period.

"(3) RECAPTURE EVENT DEFINED.—

"(A) IN GENERAL.—For purposes of this subsection, the term 'recapture event' means the failure of the taxpayer to be a qualified primary health services provider for any month during the taxpayer's mandatory service period.

"(B) SECRETARIAL WAIVER.—The Secretary, in consultation with the Secretary of Health and Human Services, may waive any recapture event caused by extraordinary circumstances.

"(4) NO CREDITS AGAINST TAX; MINIMUM TAX.—Any increase in tax under this subsection shall not be treated as a tax imposed by this chapter for purposes of determining the amount of any credit under subpart A, B, or D of this part or for purposes of section 55."

(b) CLERICAL AMENDMENT.—The table of sections for subpart A of part IV of subchapter A of chapter 1 is amended by inserting after the item relating to section 22 the following new item:

“Sec. 23. Primary health services providers.”

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1994.

SEC. 11902. EXPENSING OF MEDICAL EQUIPMENT.

(a) IN GENERAL.—Paragraph (1) of section 179(b) (relating to dollar limitation on expensing of certain depreciable business assets) is amended to read as follows:

“(1) DOLLAR LIMITATION.—

“(A) GENERAL RULE.—The aggregate cost which may be taken into account under subsection (a) for any taxable year shall not exceed \$17,500.

“(B) HEALTH CARE PROPERTY.—The aggregate cost which may be taken into account under subsection (a) shall be increased by the lesser of—

“(i) the cost of section 179 property which is health care property placed in service during the taxable year, or

“(ii) \$10,000.”

(b) DEFINITION.—Section 179(d) (relating to definitions) is amended by adding at the end the following new paragraph:

“(11) HEALTH CARE PROPERTY.—For purposes of this section, the term ‘health care property’ means section 179 property—

“(A) which is medical equipment used in the screening, monitoring, observation, diagnosis, or treatment of patients in a laboratory, medical, or hospital environment,

“(B) which is owned (directly or indirectly) and used by a physician (as defined in section 1861(r) of the Social Security Act) in the active conduct of such physician’s full-time trade or business of providing primary health services (as defined in section 330(b)(1) of the Public Health Service Act) in a health professional shortage area (as defined in section 332(a)(1)(A) of the Public Health Service Act), and

“(C) substantially all the use of which is in such area.”

(c) RECAPTURE.—Paragraph (10) of section 179(d) is amended by inserting before the period “and with respect to any health care property which ceases to be health care property at any time”.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to property placed in service in taxable years beginning after December 31, 1994.

PART 2—HEALTH-RELATED PROGRAMS TRUST FUND

SEC. 11911. HEALTH-RELATED PROGRAMS TRUST FUND.

(a) IN GENERAL.—Subchapter A of chapter 98 (relating to trust fund code) is amended by adding at the end the following new section:

“SEC. 9512. HEALTH-RELATED PROGRAMS TRUST FUND.

“(a) CREATION OF TRUST FUND.—

“(1) IN GENERAL.—There is established in the Treasury of the United States a trust fund to be known as the ‘Health-Related Programs Trust Fund’.

“(2) ACCOUNTS IN TRUST FUND.—The Health-Related Programs Trust Fund shall consist of—

“(A) a Lead Paint Abatement Program Account,

“(B) a Biomedical Research Program Account,

“(C) a Health Care Workforce Account, and

“(D) an Undergraduate Medical Education Program Account.

Each such Account shall consist of such amounts as may be appropriated or credited to such Account as provided in this section or section 9602(b).

“(b) LEAD PAINT ABATEMENT PROGRAM ACCOUNT.—

“(1) TRANSFERS TO ACCOUNT.—There are hereby appropriated to the Lead Paint Abatement Program Account for each fiscal year the amount of \$500,000,000.

“(2) EXPENDITURES FROM ACCOUNT.—Amounts appropriated under paragraph (1) to the Lead Paint Abatement Program Account are available each fiscal year to the Secretary of Health and Human Services for carrying out subtitle D of title VII of the Health Security Act.

“(c) BIOMEDICAL RESEARCH PROGRAM ACCOUNT.—

“(1) TRANSFERS TO ACCOUNT.—There are hereby appropriated to the Biomedical Research Program Account amounts equivalent to 25 percent of the net

revenues received in the Treasury from the tax imposed by section 4375 (relating to tax on health insurance and health-related administrative services).

"(2) EXPENDITURES FROM ACCOUNT.—Amounts appropriated under paragraph (1) to the Biomedical Research Program Account are available each fiscal year to the Secretary of Health and Human Services for carrying out subtitle G of title VII of the Health Security Act.

"(d) HEALTH CARE WORKFORCE ACCOUNT.—

"(1) TRANSFERS TO ACCOUNT.—There are hereby appropriated to the Health Care Workforce Account amounts equivalent to 50 percent of the net revenues received in the Treasury from the tax imposed by section 4375 (relating to tax on health insurance and health-related administrative services).

"(2) EXPENDITURES FROM ACCOUNT.—Amounts appropriated under paragraph (1) to the Health Care Workforce Account are available each fiscal year to the Secretary of Health and Human Services for making payments under sections 7011(a) and 7013 of the Health Security Act.

"(e) UNDERGRADUATE MEDICAL EDUCATION PROGRAM ACCOUNT.—

"(1) TRANSFERS TO ACCOUNT.—There are hereby appropriated to the Undergraduate Medical Education Program Account for each fiscal year the amount of \$50,000,000.

"(2) EXPENDITURES FROM ACCOUNT.—Amounts appropriated under paragraph (1) to the Undergraduate Medical Education Program Account are available each fiscal year to the Secretary of Health and Human Services for carrying out section 7102 of the Health Security Act.

"(f) NET REVENUES.—For purposes of this section, the term 'net revenues' means the amount estimated by the Secretary based on the excess of—

"(1) the taxes received in the Treasury under section 4375, over

"(2) the decrease in the tax imposed by chapter 1 resulting from the tax imposed by such section."

(b) CLERICAL AMENDMENT.—The table of sections for such subchapter A is amended by adding at the end thereof the following new item:

"Sec. 9512. Health-Related Programs Trust Fund."

II. INTRODUCTION

BACKGROUND

The amendment in the nature of a substitute to H.R. 3600 reported by the Committee would assure health security for all Americans. It would meet the goals set forth by President Clinton for health care reform through a program of universal health coverage, cost containment, and a fair way to share the costs of health care. The Committee proposal builds upon the best of the President's proposal as well as the best of the current system. It would provide a simple, affordable, and logical way to create a better American health care system.

Universal Coverage

Under the Committee amendment, by January 1, 1998, every American would be assured coverage through a health insurance plan that provides at least a national standard set of benefits.

Universal coverage would be achieved through shared responsibility: a requirement that individuals purchase health insurance, employers contribute to the cost for their employees and dependents, and the government provide subsidies for low-income families who cannot afford health insurance on their own. States would be given broad flexibility to develop alternative approaches to achieving universal coverage.

Expansion of Employer-based System

The Committee amendment would build on the existing health insurance system. Today two-thirds of Americans receive health in-

insurance coverage through their employer or the employer of a family member. For half of the 38 million Americans currently uninsured who work full time or are dependents of full-time workers, the employer-based system simply would be expanded to include them. Low-wage small employers would be eligible for subsidies of up to fifty percent of their health insurance obligation.

For the great majority of Americans who are insured today, including Medicare beneficiaries, the Committee amendment would make few visible changes in how they get their coverage or their health care.

For those not connected to the work force and for part-time and seasonal workers, a new Medicare Part C would be created. Employers with 100 or fewer employees would be able to insure their workers by enrolling in Part C. Also, those eligible would not have this as their only option, but the creation of Medicare Part C would ensure that all Americans have access to an affordable health plan. The premium would be set at a level sufficient to pay for the benefits provided by the Part C plan.

Employers would offer employees a choice of health plans that cover the guaranteed national benefit package: a managed care plan and a plan that offers an unlimited choice of providers. In addition employers could offer employees a high deductible plan combined with a tax-preferred medical savings account.

Market Reforms and Cost Containment

Under the Committee amendment, the insurance market would be reformed, eliminating cherry-picking, pre-existing condition exclusions, and arbitrary limits on certain illnesses and disabilities. Community rating—without adjustment for age or illness—would apply to plans sold to individuals and to employers of 100 employees or less. Administrative simplification would reduce the paper-work and red tape for doctors and hospitals.

The creation of a standard benefit package and supplemental insurance policies would allow consumers to compare plans more easily. With universal coverage, premium growth would be slowed due to reduced cost shifting and from slowing the overall rate of growth rate in health care costs.

A National Health Cost Commission would be charged with recommending to Congress whether the system of private-sector cost containment in the Committee amendment would go into effect on January 1, 2001, or would be modified. The Commission's recommendations would be given "fast track" review by the Congress. If Congress did not decide to do otherwise, and if expenditures in a State were in excess of target rates of growth specified in the amendment, the back-up cost containment provisions in the amendment would be applied in those States not meeting the targets.

Guaranteed Benefits, Freedom of Choice

Under the Committee amendment, a guaranteed national benefit package would be defined to include the benefits currently provided under Medicare, plus unlimited hospital care, coverage of prescription drugs, preventive services for children without cost sharing, pregnancy-related services, and comprehensive mental health and

substance abuse services. Prescription drug coverage would also be added to the current Medicare program for seniors.

Under the Committee amendment, individuals would be guaranteed the right to choose their own doctor.

Long-term care

An important first step in providing needed services to individuals with severe disabilities would be included through a new program to cover long-term home and community-based care. Benefits would be provided to individuals without regard to age or income.

Ensuring Quality and Consumer Protection

The quality of health services would be protected and improved through the creation of a national quality improvement program, including standards for utilization review procedures and due process standards for health care providers. Health insurers would be required to produce annual report cards on the quality of care provided and the level of patient satisfaction in their plans. Medical research would be expanded. Additional outcomes research would be conducted, and a clearinghouse for dissemination of practice guidelines would be created.

An expanded national anti-fraud and abuse program would facilitate the coordination of State, local, and Federal efforts to investigate and prosecute fraudulent activities. Patient privacy protections would be established.

SUMMARY

Title I. Health Care Security

A. Universal Coverage

Each eligible individual would be entitled to health insurance that includes coverage of at least a guaranteed national benefit package. Every eligible individual would be entitled to a health security card. An eligible individual would be defined to include any individual who is a citizen or national of the United States, an alien permanently residing in the United States under color of law, or a long-term nonimmigrant.

B. Protection of Consumer Choice

An individual would be free to choose his or her own health care providers, and would be free to purchase any health care services. Employers and individuals would be free to purchase supplemental insurance to cover health care services that are not covered under the guaranteed national benefit package.

Title II. Individual and Employer Responsibilities

A. Individual Responsibilities

All individuals would generally be covered under a private health plan meeting the standards specified in Title V of this bill or in Medicare Part C. The individual responsibility requirements would be effective January 1, 1998, and would be enforced through the Internal Revenue Code.

In general, any employee in a firm that offers private health insurance would not be permitted to enroll in Medicare Part C. An exception to this rule would be permitted for any low-income employee in a firm of 100 or fewer employees, and for any part-time, seasonal, or temporary employee, who would be permitted to elect coverage under Medicare Part C. Any individual not connected to the work force could elect to enroll in a private health insurance plan or Medicare Part C.

Individuals would be required to pay the premium for the guaranteed benefit package, minus the amount contributed on their behalf by their employers. The employee's share of the premium would be collected by the employer through tax withholding.

The premium would be zero for individuals with family incomes below an income threshold, approximately equal to 100 percent of the Federal poverty level. For individuals with income between the threshold level and approximately 240 percent of the poverty level, the premium would be reduced on a sliding scale basis. The upper limit for premium subsidies would be phased in, ending for individuals at approximately: 200 percent of poverty in 1998, 1999, and 2000; 220 percent of poverty in 2001 and 2002; and 240 percent of poverty in 2003 and thereafter.

A dependent child would not be required to pay the Medicare Part C premium. In addition, certain U.S. citizens living abroad, nonresident aliens, members of certain religious faiths, certain disabled veterans, active duty personnel, persons receiving Medicare Part A benefits and prisoners would not be required to pay the Medicare Part C premium.

B. Employer Responsibilities

1. General responsibilities

All employers would be required to contribute to the cost of health insurance coverage for all employees. Employers would contribute at least 80 percent of the premium of the guaranteed national benefit package for full-time employees and their dependents, based on the employee's class of enrollment. The employer would be required to make payments either to: (1) a private qualified health plan maintained by the employer, or (2) Medicare Part C. Employers would be permitted to make voluntary contributions in excess of the required 80 percent, subject to nondiscrimination rules.

Employer contributions for part-time, seasonal, and temporary workers would be computed on a pro rata basis using the ratio of the number of hours worked per week to 35 hours. Employers would be required to treat as full-time employees any employee of an institution of higher education, or of elementary and secondary schools, if the employee worked the customary hours that constitute full-time employment. Employers would not be required to contribute to coverage of any worker who is expected to earn less than \$100 (in 1994 dollars) in a given month.

Employers with more than 100 employees would have to meet this health insurance obligation for their workers, beginning January 1, 1996. Employers could meet this requirement through coverage under: a private qualified health plan; a self-insured plan, if

the employer has more than 100 employees and elects to self-insure; or a qualified State health plan (See Title IV).

Employers with 100 or fewer employees would be required to meet this health insurance obligation for workers, beginning January 1, 1998. Medicare Part C would be available to individuals in firms with 100 or fewer employees by January 1, 1998.

Any employer that offers coverage under a private health plan would be required to offer employees a choice between two categories of plans: (1) a managed-care plan or (2) a plan that provides an unlimited choice of providers (as defined in Title V). The employer would be responsible for contributing at least 80 percent of the least-cost plan within each category of the plans offered to the employee.

In addition, employers would be permitted to offer employees a plan consisting of both: (1) a high deductible health care insurance policy and (2) a medical savings account. This combination is referred to as a "high deductible medical savings plan" (See Title XI for tax treatment of medical savings accounts).

Employers would not be required to offer coverage under a private plan to a part-time employee unless the employee is expected to work for the employer for more than 25 hours per week, averaged over a three-month period. Employers would not be required to offer coverage under a private plan to a seasonal worker, unless the worker is expected to work for the employer for at least four months in a given year.

Employers would be required to have an annual open-enrollment period of at least 45 days.

A five-year maintenance-of-effort requirement would be imposed on employers that currently offer benefits in excess of the guaranteed national benefit package. Nondiscrimination rules would prohibit employers from paying greater amounts toward health coverage, or from providing more generous benefits, for certain full-time employees.

Employers would be required to extend health insurance coverage and make premium payments through the last day of the calendar month in which the employee stops working for the employer.

2. Employer responsibilities with respect to families

Employers would be required to allow family members of their employees to be covered under the employer's health plan if a private plan is offered by the employer. Employers would contribute at least 80 percent of the applicable premium, based on the class of family enrollment.

The employer who enrolls a family would receive a credit to help defray the additional costs associated with family coverage. The credit would be financed by premiums paid by employers whose workers were covered as dependents under another employer's health plan. The credit would be phased in over a transition period.

3. Small business credits

Employers with 50 or fewer employees could be eligible for a tax credit which would reduce their liability for health premiums and

other employment taxes, depending on the wage level of their employees. Employers would be eligible for the credit if the number of employees employed by the employer for the year does not exceed 50 and the average full-time equivalent salary paid to employees is less than \$26,000 per year. The maximum credit for those firms with 25 or fewer employees would be 50 percent. The maximum credit for employers with 26–50 employees would be 37.5 percent. The maximum credit would be available if the employer pays an average full-time salary of \$12,000 or less, and would phase down to zero for employers who pay an average full-time salary of \$26,000. An employer's deduction for providing health insurance would be reduced by the amount of the credit.

4. Employer obligations for retirees

Employers who, as of October 1, 1993, were paying a portion of the health costs for retirees ages 55 through 64 and their spouses and dependents, would be required to continue coverage. An employer could meet this obligation by paying at least 80 percent of the premium under: a private health plan; a self-insured plan, if applicable; or Medicare Part C, beginning in 1998. A maintenance-of-effort rule would require employers with contractual retiree health obligations that exceed benefits under the guaranteed national benefit package to provide such benefits to retirees, spouses, and dependents, consistent with contractual obligations.

5. Continuation of health benefits under COBRA extension

Continuation of health insurance coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) would be extended during a transitional period between the date of enactment and January 1, 1998. During this period, the current-law coverage limits on the duration of COBRA coverage would be extended. COBRA coverage would terminate the earlier of: (1) coverage of an employee or beneficiary under an employer-sponsored plan which does not contain any exclusion or limitation with respect to any preexisting condition of the employee or beneficiary; (2) coverage of an employee or beneficiary under the current Medicare program, or (3) the establishment of the Medicare Part C plan, January 1, 1998. After the transitional period ending January 1, 1998, the COBRA duration of coverage would revert to current law. As under current law, and employees would be permitted to extend coverage under the employer plan, at the employee's expense.

6. Exemptions

Employers of children under age 19 (under 24 in the case of a full-time student) would not be required to contribute on behalf of these employees, provided they are covered under a parent's health plan. In addition, employer contributions would not be required with respect to services performed at a "sheltered workshop," nor with respect to members of certain religious faiths, certain disabled veterans, active duty military personnel, persons receiving Medicare Part A benefits, and prisoners.

Title III. Benefits

A. Guaranteed National Benefit Package

The guaranteed national benefit package would be included under Medicare Part C, and would be offered by all private health insurers, and by employers with self-insured plans. Individuals and employers would be permitted to purchase supplemental policies for coverage of additional benefits and cost sharing.

The guaranteed national benefit package would include the benefits currently covered under Medicare Parts A and B, with several improvements. The benefit package also would include: a single deductible of \$500 per individual/\$750 per family and coverage of outpatient prescription drugs, with a separate \$500 deductible, 20-percent cost-sharing, and \$1,000 out-of-pocket cap, which would be indexed annually. Inpatient services would be covered without co-insurance, deductibles or spell-of-illness restrictions. Beginning in 2003, a cap on out-of-pocket expenditures would be added to the guaranteed national benefit package set at \$5,500 per individual (in 1994 dollars) and would be indexed in subsequent years. An alternative cost-sharing schedule would be established for managed-care plans.

Additional services for children up to age 18 would be covered under the guaranteed national benefit package, with no cost sharing. Newborn and well-baby care would be consistent with the services and periodicity schedule specified by the Secretary, in consultation with the American Academy of Pediatrics, including pediatric attendance at high-risk deliveries. Well-child services, including routine office visits, routine immunizations, routine lab tests, dental care, periodic lead screening as recommended by the Center for Disease Control, and child-abuse assessment, would be covered without cost sharing. Hearing aids for children would be covered. Medically necessary food would be covered for persons with Phenylketonuria (PKU) and other inborn errors of metabolism.

All pregnancy-related services and family-planning services would be covered.

Additional preventive benefits would be covered, such as immunizations, mammography screening, pap smears, and colorectal screening, including colonoscopies. Mammography screening would be modified to cover mammograms once per 11-month period, rather than once per 23-month period, for women ages 65 and older. The Secretary would be given the authority to add to or modify coverage of vaccinations and other clinical preventive benefits, provided such services were determined to be clinically appropriate and cost effective.

Coverage of chiropractic services would be modified to include the x-ray services necessary for meeting the requirements under the guaranteed national benefit package.

A new mental health and substance abuse benefit would be established that would provide access to a continuum of services emphasizing community and residential settings. The mental health benefit package would include intensive residential and community services and outpatient mental health services, with reduced copayments for children up to age 18. Inpatient services would be

limited to 60 days in general and psychiatric hospitals, with no lifetime limit on days in psychiatric hospitals.

In addition, States would be given broad flexibility to establish comprehensive, managed, mental health programs for low-income adults and children with serious mental illness or emotional disturbances. The programs would allow eligible individuals to continue to receive the services defined in the guaranteed national benefit package for mental health, but without limits, and at the State option, with reduced copayments.

A new Commission on Mental Health and Substance Abuse would be established to examine whether the benefits covered under the guaranteed national benefit package assure appropriate coverage for mental health and substance abuse problems. It would also study the progress that has been made in achieving parity between these services and other health services. The Commission would have the authority to review a wide range of issues related to mental illness and substance abuse.

Coverage would include items and services provided to patients participating in approved clinical trials for treatment of cancer and other medical conditions, provided such services are otherwise covered under the guaranteed national benefit package.

The Secretary would be directed to conduct studies on emergency dental services and payment methodologies for pharmacist services, and would be directed to conduct a demonstration of sub-acute care.

B. Coverage of Outpatient Prescription Drugs

Outpatient prescription drugs, biological products, insulin, and home infusion drugs would be added to the services covered under Medicare Parts B and C. The separate deductible for the prescription drug benefit would be set at \$500 and the out-of-pocket limit would be set at \$1,000 (in 1994 dollars) and would be indexed in subsequent years. Payments would be 80 percent of the lesser of the actual charge for the drug, or the Medicare payment limit.

Payment limits would vary depending upon whether the drug is a single-source or multiple-source drug with a restrictive prescription, or a multiple-source drug without a restrictive prescription. The limits would be updated subject to the target rate of increase for the prescription drug sector.

In order for payment to be available under Medicare, manufacturers would be required to enter into and have in effect a rebate agreement with the Secretary. A flat rebate of 15 percent would apply to single-source and innovator multiple-source drugs, and a flat rebate of 10 percent would apply to generic drugs and over-the-counter insulin. As part of the rebate agreement, a manufacturer would be required to guarantee that the manufacturer would offer prescription drugs at the same price to each wholesaler or retailer purchasing such drugs on substantially the same terms as any other purchaser.

There would be mandatory assignment for all covered outpatient drugs. The administrative allowance would be set at \$5 per prescription (in 1994 dollars) and would be indexed in subsequent years. Pharmacists would be required to submit claims to Medicare carriers through a point-of-sale electronic system. The Secretary

would establish a program to assure appropriate prescribing and dispensing practices under Medicare. The Secretary would conduct a study to develop a payment methodology for pharmacist services.

Only providers of home infusion drug therapy, who meet requirements established by the Secretary, would qualify to provide covered home infusion drug therapy services. Home infusion therapy would be required to be provided in the place of residence used as the individual's home or in another setting determined by the Secretary to be cost effective.

An 11-member Prescription Drug Payment Review Commission would be established. A representative from a research-based pharmaceutical and biotechnology company would sit on the Commission. The Commission would submit an annual report to Congress regarding increases in prescription drug prices, use of covered drugs administrative costs relating to covered drugs, and payments for prescription drugs under the national health expenditure estimates. In addition, the Commission would be required to publish a consumer guide to prescription drugs. The guide would include information that the Commission determines would assist consumers in reducing their expenses for prescription drugs and providers in determining the most cost-effective drug.

The Part B premium would be adjusted to finance 25 percent of the cost of the prescription drug benefit provided under Medicare Part B.

C. Other Changes in Medicare Benefits

In general, the current Medicare benefit package would be improved to include newborn services, well-baby services, well-child services, pregnancy-related services, family-planning services, drugs and devices, outpatient prescription drug coverage, mental health services, and additional preventive services, consistent with the benefits covered under the guaranteed national benefit package. Inpatient mental health services would be limited to 60 days in general and psychiatric hospitals, with no lifetime limit on days in psychiatric hospitals. The 60-day limit on lifetime reserve days for inpatient hospital care would be eliminated; the coinsurance requirements that apply to lifetime-reserve days would be retained.

Beginning in 2003, a cap on out-of-pocket expenditures would be established and set at \$5,500 per individual (in 1994 dollars) and would be indexed in subsequent years.

Medicare coverage of mammography screening would be modified to cover mammograms once per 11-month period, rather than once per 23-month period, for women ages 65 and older.

Medicare coverage of chiropractic services would be expanded to include coverage of those x-rays that are necessary for chiropractic services to meet the requirements of coverage under Medicare.

Medicare would be required to make available to beneficiaries the choice of a managed-care plan, if available, or an unlimited choice of providers which could involve a point-of-service option.

D. Other Provisions Relating to Benefits

The preemption of State laws providing for reimbursement to a class of providers would be prohibited for health plans other than

Medicare Parts A, B, and C, provided the provider is legally authorized under State law to provide the item or service.

A new National Health Advisory Commission would be established to monitor the impact of the Health Security Act on individuals, on employers and on government, and would report at least annually on their findings. Such recommendations could include, but would not be limited to possible changes in benefits, changes in national health estimates, and changes in insurance regulation. The Advisory Commission would be appointed in the same manner as the Prospective Payment Assessment Commission and the Physician Payment Review Commission, and would serve in an advisory capacity to the Congressional committees of jurisdiction.

Title IV. State Responsibilities

States would be given broad flexibility to establish their own health care reform systems. The Secretary's approval could be granted for two types of authority: (1) State control solely over provider reimbursement, either as a whole or sector-by-sector (e.g., physician services or hospital services); and (2) State authority over all health care benefits provided in the State, including self-insured plans.

States seeking approval for a system would be required to demonstrate to the Secretary that total expenditures in the State for the services covered under the State system could not exceed expenditures that would have been made if the State system were not in effect. In addition, total Medicare expenditures (including Medicare Part C) for services covered under the State system could not exceed total Medicare expenditures that would have been made if the State system were not in effect.

In general, employers would be required to participate in an approved State program, either an all-payer provider-reimbursement system or a benefit-management program.

An exception to the general requirement would be provided with respect to a State benefit-management program. Under the exception, any employer that: (i) sponsors a self-insured health plan meeting the Federal requirements for such plans; (ii) has a total of at least 5,000 employees nationally; and (iii) has employees located in at least two States, would not be required to participate in an approved State benefit-management program. All employers would, however, be required to participate in approved State provider-reimbursement systems.

With respect to State health care benefit plans, a State plan would have to provide coverage for at least the guaranteed national benefit package for all residents, other than residents covered under Medicare Parts A through C. Guarantee of coverage could be through a State single-payer or public plan, an employer mandate, a combination of public and private coverage, competing health plans, managed competition, or any other system, provided that it covered all residents.

States could apply to include individuals entitled to benefits under Medicare Part C in the State program. After three years of experience with the State plan, a State could also apply to integrate into the State system coverage of individuals entitled to Medicare Parts A and B. Federal payments that would otherwise be

made to State residents for premium subsidies, wrap-around benefits, and payments made on behalf of Medicare beneficiaries could be paid directly to a State operating an approved benefit-management program, offset by any Medicaid maintenance-of-effort payments owed by the State (described in Title VIII). The State would be required to demonstrate that under the State program, individuals entitled to Federal subsidies or additional Federal benefits would not incur additional financial liability under the State program.

Title V. Health Plans and Health Alliances

A. Establishment of Federal Standards

By July 1, 1995, the Secretary would promulgate regulations to implement Federal standards for health plans sold to individuals and employers.

States would be required to apply the Federal standards to health plans sold to individuals and employers beginning on January 1, 1997, except that the deadline would be January 1, 1998, for States in which the legislature is not scheduled to meet during calendar year 1996. The Secretary would certify State compliance and would assume responsibility for enforcing the standards in a State that did not comply. Civil monetary penalties would be established for plans found in violation of the Federal standards, subject to provisions of section 1128A of the Social Security Act. In addition, the Secretary could withhold Federal financial assistance in the case of a State that is not in compliance with the adoption and enforcement of Federal standards, and refer matters involving non-complying health plans to the U.S. Attorney General for further action.

The States would continue to regulate financial solvency of health insurance using standards at least as stringent as model standards developed by the National Association of Insurance Commissioners.

B. Federal Standards for Health Plans Sold to Employers and Individuals

Health insurance would be sold in five market sectors: individual, small group (employers with 2 to 100 employees), large group (employers with more than 100 employees), association, and alliance. A carrier could choose to sell insurance in one or more market sectors.

The association market would include associations, religious fraternal organizations, or other organizations certified by the Secretary as having been formed for purposes other than the sale of health insurance, and with at least 1,000 individual members or 200 employer members, and who offered insurance as of December 31, 1993. Associations would include trade associations, industry associations, professional associations, chambers of commerce, and other public entity associations, including their wholly-owned subsidiaries or corporations the total ownership of which is owned by one or more associations.

Carriers would be required to provide for open enrollment of groups and individuals. Plans sold in the individual market would be sold during an open-enrollment period established by the State lasting at least 45 days. During their first year of enrollment in the individual market, an individual could choose to switch among health plans offered outside of the annual open-enrollment period if the individual gave 45-days notice before the effective date of the change in health plans could take effect. The individual could make such a change only once within the year. After the first year, changes could only be made during the open-enrollment period.

Plans sold in other markets would be sold on a continuous open-enrollment basis, although employers and sponsors of self-insured plans could establish annual open-enrollment periods of no less than 45 days during which an employee could switch among plans offered by the employer. Transitional rules would provide for annual open enrollment in the small group market until January 1, 1998, when the individual and small employer mandates take effect.

In all markets, coverage would be guaranteed renewable, and plans could not deny or limit coverage based on a pre-existing condition. No waiting periods would be permitted. A transitional rule would prohibit exclusions for pre-existing conditions for individuals with previous coverage and would limit exclusions to six months for newly insured individuals until January 1, 1998, when the individual mandate would take effect and pre-existing condition exclusions would be eliminated for all individuals.

Antidiscrimination rules would prohibit plans from engaging directly or indirectly in activities that would have the effect of discriminating against an individual.

Health plans would be required to offer the guaranteed national benefits as a separate package. Benefits would be offered under fee-for-service, managed care, and point-of-service options (combining fee-for-service and managed-care cost-sharing schedules). Carriers could also offer to employers, but not individuals, the guaranteed national benefit package as a high-deductible option under which a single deductible between \$1,500 and \$2,500 for an individual and \$2,150 and \$3,750 for a family would apply.

In each market, except the large group market, carriers would be required to sell the guaranteed national benefit package at premiums that are community rated. Premiums could vary only for the three enrollment categories (individual, single parent, and family) and by geographic area. Carriers would be allowed to phase in community-rated premiums over a three-year period.

Health plans sold through a regional health alliance would be sold at the community rate that would otherwise apply in the individual or small group markets, adjusted by an administrative discount negotiated between the carrier and the alliance to reflect the administrative functions performed by the regional health alliance.

Managed care plans would have to meet additional requirements pertaining to arrangements with physicians and the availability and accessibility of medically necessary services. Services covered by a managed care plan outside the plan network where medically necessary and immediately required services would include cov-

erage of trauma-care services provided by designated trauma centers.

Health plans would be required to permit enrollees to obtain services outside the plan's provider network at the discretion of the enrollee. The Secretary would establish an alternative cost-sharing schedule that would apply to medically necessary and appropriate out-of-network services. In the case of a denial of in-network treatment or services by the plan, the enrollee would have the right to an expedited appeals process.

Health plans would be required to demonstrate that enrollees have access to the specialized treatment expertise of designated centers of excellence. The Secretary would designate as centers of excellence facilities that provide specialty care, deliver treatment of chronic diseases and other complex cases requiring specialized treatment, and meet other requirements established by the Secretary.

Federal standards for marketing of health plans would be established. Marketing materials would be required to be approved in advance, and each State would make available to consumers information in a uniform format on approved health plans sold in the State. Materials could not be used to attract or limit enrollment of certain individuals or groups.

The Secretary would be required to develop one or more interim model risk-adjustment systems that would be issued with the Federal standards for health plans by July 1, 1995. Each State would be required to adopt a risk-adjustment system that would apply to all carriers selling health plans in the State.

Health plans would be required to offer contracts to all essential community providers in the plan's service area. The following would be designated as essential community providers: certain urban hospitals that would qualify as disproportionate share hospitals under Medicare (including children's hospitals with fewer than 100 beds); Federally Qualified Health Centers (FQHCs); family-planning clinics receiving funding under Title X of the Public Health Service Act; not-for-profit diagnostic and treatment centers and clinics that provide primary care services (including obstetrics and gynecology), are located in an underserved area, and are licensed by the State under a State law in effect as of January 1, 1994; local health departments; sole community hospitals; rural health clinics; rural Medicare-dependent hospitals; and individual health providers in medically underserved areas. The terms of contracts could not be less favorable than those with other participating providers. Payment to FQHCs and rural health clinics would be based on Medicare reasonable cost rates.

Plans would be required to meet standards established in Title IX pertaining to grievance procedures, quality assurance and consumer protection requirements, and administrative simplification.

Health plans would be required to meet Federal utilization-review standards established by the Secretary and to disclose to consumers and the State requirements for utilization review, loss-ratio information on the health plan, and any exclusion in the types of providers participating in the health plan. All health plans would

be prohibited from requiring a physician referral for obstetrics and gynecology services.

Standards for contracts between managed-care plans and providers would be established. Standards would provide for public notice when applications by participating providers are to be accepted, notification of a decision to terminate a provider, and opportunity for review of the termination.

Under the Committee bill, no health provider who is qualified under the terms of a health plan offered by a carrier and willing to accept the plan's operating terms including, but not limited to, its schedule of fees, covered expenses and quality standards, could be denied the opportunity to participate in that plan. Nothing in the Committee bill would prevent a carrier from instituting credentialing criteria, requiring fee discounts, matching the availability of health care providers to the needs of the patients enrolled in the plan, or establishing any other measure designed to maintain quality or control costs. Dedicated group and staff model Health Maintenance Organizations (HMOs) would be exempted from this provision.

The Committee bill provides that, subject to the conditions specified, States, health alliances, or State regulatory authorities should not interfere with the ability of health insurers to contract with and pay compensation to brokers and agents.

C. Requirements for Supplemental Benefit Plans

Supplemental benefit policies sold to individuals and employers would be restricted to those provided in up to 10 standardized supplemental benefit packages which would be defined by the Secretary. Supplemental benefit policies would be required to meet Federal standards for open enrollment and community rating. The sale of supplemental benefits could not be tied to the sale of the guaranteed national benefit package or any other policy, except that managed care plans would be prohibited from selling supplemental benefit coverage to individuals other than those enrolled in the managed care plan for the guaranteed national benefit package.

In defining supplemental benefit packages, the Secretary would be directed to take into account current State laws. State laws that require health plans to offer benefits in addition to the guaranteed national benefit package would be preempted. The Committee bill would not preempt, with respect to health plans other than Medicare Parts A, B, and C, State laws providing for reimbursement to a class of providers with respect to services which the provider is legally authorized to provide under State law.

The sale of an insurance plan that duplicates benefits included in the guaranteed national benefit package or included in one or more of the standardized supplemental benefit packages would be prohibited. Long-term care insurance, accident-only insurance, disability-income insurance, hospital- or fixed-indemnity insurance, insurance that limits coverage to specific diseases or conditions, coverage as a supplement to liability insurance, workers compensation or similar insurance, automobile insurance, and insurance sold to exclusive individuals that are not required to be covered under the guaranteed national benefit package would not be considered

to duplicate benefits if the plan always pays benefits regardless of other coverage.

Standardized benefits for Medicare supplemental-benefit insurance (Medigap) policies would be conformed to the changes made in the benefits covered under Medicare Parts A and B. Medigap plans would be required to be made available to any individual without application of a pre-existing condition exclusion during an annual 30-day open-enrollment period.

D. Requirements for Self-Insured Employer Plans

Limits on self-insurance would be established. Effective January 1, 1998, employers with 100 employees or less and Multiple Employer Welfare Arrangements (MEWAs) would be prohibited from self-insuring.

Self-insured employer plans would have to be certified annually by the Secretary as meeting Federal standards. Civil monetary penalties would be established for plans found in violation of the Federal standards, subject to provisions of section 1128A of the Social Security Act.

Self-insured employer plans would be required to provide the guaranteed national benefit package, but could provide additional benefits as well. Plans could not deny or limit coverage or vary premium contributions charged to any eligible individual based on a pre-existing condition, claims experience, or medical history. Waiting periods for coverage would be prohibited, and plans would be required to meet standards specified by the Secretary with respect to grievance procedures, quality assurance, and administrative simplification. Managed-care plans provided by the sponsor of a self-insured plan would be required to meet the same standards that would apply to managed-care plans sold to individuals and employers.

E. Transitional Insurance Reforms

Transitional insurance reforms would be established and effective in each State beginning on January 1, 1995, until the Federal standards described above take effect in the State. Federal requirements would not preempt any existing State law that is more stringent.

Under the transitional insurance reforms, health plans would be required to maintain coverage in force and to accept new members in a group plan without respect to health status. Exclusions for pre-existing conditions would be prohibited for individuals with previous coverage and would be limited to six months for newly insured individuals.

Insurers would have to apply consistent rating policies with respect to demographic characteristics and changes in benefit design across all covered individuals and groups. Premium increases for individual plans and small group plans (less than 100 employees) could not vary based on claims experience.

Health plans would be required to file a certification with the Secretary or the State indicating that they are in compliance with the transitional insurance reform requirements. Self-insured employer plans would be prohibited from reducing or limiting cov-

erage with respect to any medical condition for which the cost of treatment is expected to exceed \$5,000 a year.

Transitional insurance reform requirements would be enforced by the Secretary, with violators subject to a civil monetary penalty up to \$25,000 for each violation. The Secretary could elect to enter into agreements with States to enforce the requirements.

F. Health Alliances

Voluntary regional health alliances could be established by a State or by a local government with an MSA-wide population of at least one million. Employer participation generally would be voluntary, although participation could be mandatory under an approved State plan as described in the preceding section.

For the five-year period beginning in fiscal year 1995, \$150 million in grants would be authorized to assist States and qualified local governments in the planning, development, and initial operation of regional health alliances. In order to be eligible for Federal grants, a State alliance program would have to meet certain requirements.

Under the grant program, an alliance could be operated by a State agency, a municipal or county government, or a non-profit organization. States could provide for division of the State into more than one area, and one or more contiguous States could provide for the establishment of an inter-State alliance. The alliance would be required to be governed by a Board of Directors representing employers and consumers, represented in equal numbers. The governing board could not include providers or representatives of health plans and would be required to reflect the racial and ethnic composition of the region served.

Under the grant program, regional health alliances would enter into agreements with any health plan meeting Federal standards that seeks to offer health insurance through the alliance. Alliances would offer to enter into agreements to provide services to any employer in the alliance area with fewer than 100 employees. Regional health alliances would make similar services available to individuals and families who are not employees of participating employers but who reside in the alliance area and assist eligible individuals in enrolling in Medicare Part C.

A State could designate a regional health alliance to enforce a State capital allocation plan for the review of health care related capital expenditures.

Title VI. Standby Cost Containment in the Private Sector

A. National Health Expenditure Estimates

The Secretary would estimate in 1995 total national health expenditures under Medicare and under private plans, and the baseline rates of growth for future years. The estimate of health spending in the private sector would include spending for services covered under the national guaranteed benefit package, under supplemental policies, and for related cost sharing.

The national health spending estimates would be established on a per-capita basis and would be adjusted for shifts in enrollment

between the public and private sectors. Target rates of growth for spending by private plans in each year would be set by statute, beginning with 1996. The target rate of growth would be set so that the rate of growth in private spending on health care would be reduced by two-percentage points in 1996, and by an additional one-percentage point in each subsequent year until the rate of growth is slowed to the five-year average per capita rate of growth in the gross domestic product (GDP).

The private sector expenditure estimate for 1998 would be adjusted to reflect the effects of universal coverage and the implementation of Medicare Part C.

B. Allocation of National Estimates to Classes of Services and States

The estimate of health spending in the private sector would be allocated to various classes of health services, such as inpatient hospital services and physician services, based upon the historic share and growth rates attributable to each class. The allocation to each sector within each class would then become an overall target attributable to each type of health service, such as hospital or physician services. Once established, these allocations could only be changed through legislation.

The estimate also would be allocated to each State to monitor the State's success in controlling health care costs. The allocation would be based on the prices in each State that would apply under the maximum payment rate system and utilization patterns within each State. The State allocations would grow at the same rate as the national health spending estimate for the private sector.

Health providers would report information to the Secretary to permit monitoring of health care spending within each State.

C. Standby Federal Cost Containment

States and health care providers would not be subject to the system of standby maximum payment rates for at least the initial five years (1996 through 2000) and for subsequent years, if the private per-capita health spending within a State remained below the target level of spending. If, in any year beginning with 2001, health care spending in the private sector in a State is greater than the private-sector health-spending estimate for the State for that year, then the standby Federal cost-containment system would become effective for all services in that State in the second following year.

The application of the maximum payment rates in a State could be changed or modified as a result of recommendations by the Health Care Cost Commission and subsequent Congressional action as described below. However, in the absence of such recommendations and action, the Secretary would be required to implement use of the maximum payment rates in a year after 2000 if a State exceeded its estimate during the second preceding year.

States with approved State cost-containment or health care reform systems whose spending is less than their State targets would retain control over their system.

D. Maximum Payment Rates

Under the Federal standby cost-containment system, private plans would make payments under maximum payment limits based on Medicare methodologies. These rates would be set so that spending under these rates would be consistent with the private sector spending estimate. The rates would be set at the level of spending which would have been achieved if the limit on payment rates had been in effect since 1996. Annual updates in the limits on payment rates would be consistent with keeping expenditures within the estimate, subject to the declining growth rates in the national health estimates over time.

Fees for medical services charged to property/casualty insurers could not be less favorable than the fees for similar services (without regard to cost sharing) that would be paid by the patient's health insurance plan.

E. National Health Cost Commission

A National Health Cost Commission would be established. The Commission would consist of nine members to be appointed by the President based on their expertise and national recognition in the fields of health economics, provider reimbursement, health insurance, and health-benefits design.

The Commission would conduct analyses of health care costs. Beginning in 1998, the Commission would submit an annual report to Congress. The report would include analysis of: the rate of growth in costs by type of provider, by type of payer, and by State; the success or failure of the private sector in staying within national health estimates on a State-by-State basis; the impact of universal coverage on health care costs and on payments for services by private payers; and projections of growth in health care costs.

In 2000, the report of the Commission could include a specific finding regarding whether a system of cost containment should be imposed on health care services provided under private health insurance plans. The Commission could recommend that the system of private-sector cost containment described above be allowed to go into effect, or the Commission could recommend an alternative system. The recommendations could include any cost-containment measure the Commission wished to recommend but could not relate to a change in the guaranteed national benefit package.

The Commission's recommendations in 2000 would be considered by the Congress following a "fast track" procedure, if accompanied by a statement provided by the Director of the Congressional Budget Office (CBO) that the recommended system would meet the stated cost-containment objectives. The Committees of jurisdiction could amend the recommendations. If a recommendation is amended, the Commission's original recommendation would be considered on the floor of each House in the nature of a substitute. The time for each Committee to consider the Commission's recommendations and for debate on the floor of each House would be limited.

Title VII. Public Health Initiatives

A. Health Work-Force Priorities

The Secretary would develop and implement a national health care work-force plan. The plan would establish national goals regarding both the number and specialty of physicians that are necessary to meet national needs. The plan would provide that, after July 1, 1998, at least 55 percent of all residents would be trained in primary-care specialties. Obstetrics and gynecology would be defined as a primary-care specialty. In developing the plan, the Secretary would address ways to increase the number of nurse practitioners. The Secretary also would develop and implement a system that would designate residency positions as approved and consistent with the goals of the national health care work-force plan. The Secretary could alter the proportion of residents trained in primary care.

After July 1, 1998, residency positions that are not consistent with and approved by the Secretary would not be used in determining adjustments to the maximum payment rates or payments under Medicare for either the direct or indirect costs of graduate medical education. Teaching hospitals that lose residency positions would be eligible for transition payments.

The Secretary would conduct a study of the financial needs of schools that provide training of health care professionals, including medical schools, dental schools, and schools of public health. The Secretary would submit a report, with appropriate recommendations within 18 months of enactment.

B. Primary-Care Incentives

The system of bonus payments under Medicare for services provided in underserved areas would be redirected and increased to emphasize bonuses for primary-care services. In addition, bonus payments under Part B to physicians who serve in health-professional-shortage areas would continue for three years after the area loses its designation as a shortage area.

An Undergraduate Medical Education Trust Fund would be established. Each year, \$50 million would be deposited into the Trust Fund from the tax on health insurance premiums and self-insured plans, described in Title XI of the bill, and made available to medical schools. In order to be eligible for such funds, medical schools would be required to actively recruit minorities, and to maintain a program designed to encourage students to elect primary-care residency training. The funds would be disbursed using a formula (developed by the Secretary) that would take into consideration the proportion of students who are minorities and the number of students that elect primary-care graduate training.

C. Academic Health Centers

The maximum-payment rates for the private sector would be adjusted to reflect both the direct and indirect costs of graduate medical education. Adjustments would be provided in payments made to FQHCs to reflect the costs of training residents at FQHCs.

A Healthcare Work-force Trust Fund would be established, effective January 1, 1996. The Trust Fund would receive one-half of the revenues collected by the two-percent tax on health insurance premiums and self-insured plans described in Title XI. Payments would be made to hospitals from the Trust Fund to pay the private-sector share of the direct and indirect costs of graduate medical education. The priority of payments from this Fund would first pay the private share of the direct costs of graduate medical education. If there are residual funds after paying these amounts, the Fund would be used to contribute toward the private-sector share of the indirect costs of graduate medical education. The maximum payment rates would be reduced to the extent that payments for the direct and indirect costs of graduate medical education are made from the Trust Fund.

Demonstration projects, relating to Medicare payments to consortia of hospitals for the direct and indirect costs of graduate medical education, would be authorized. In addition, the Secretary would study the feasibility and appropriateness of making payments for the direct and indirect costs of graduate medical education for residents who train in sites other than hospitals.

D. Essential Health Facilities

Medicares Essential Access Community Hospital (EACH) program for rural health networks would be expanded from seven States to all States, and program improvements would be made. Authorization for facilities would be increased from \$15 million to \$40 million per year, and authorization for grants to States for creation of rural health networks would be increased from \$10 million to \$50 million per year.

An Essential Community Provider (ECP) program would be created to facilitate the organization and delivery of primary and preventive services for medically underserved populations by fostering networks of ECPs. The Secretary would make grants to States, local governments, and eligible health care facilities. Grants could be used for the expansion of primary-care sites, development of information, billing and reporting systems, recruitment and training of health professionals, or health promotion and outreach to underserved populations.

Facilities eligible for designation as ECPs include hospitals that would qualify for a Medicare disproportionate-share adjustment, FQHCs, rural health clinics, rural referral centers, and sole community hospitals located in underserved rural areas. Funding of \$160 million per year for each of the fiscal years 1996 through 1999 would be available for the ECP program.

A Capital Financing Trust Fund would be established through which the Secretary would provide capital financing assistance to eligible facilities in the form of loan guarantees, interest-rate subsidies, direct matching loans, and (in cases of urgent life and safety needs) direct grants. Up to \$970 million would be made available annually under the Trust Fund for fiscal years 1996 through 1999. Facilities eligible for capital financing assistance include EACHs, Rural Primary Care Hospitals, and certain facilities eligible for assistance under the newly established ECP program. An additional \$50 million a year would be made available for transitional capital

financial assistance to academic health centers with major facility-replacement projects.

E. Other

The Secretary would contract with State and local governments for the purpose of reducing the risk of lead-paint exposure through risk assessment and lead-paint abatement activities. A Lead Abatement Trust Fund would be established and \$500 million annually from the tax on health insurance premiums would be transferred to the Trust Fund to finance the program.

A Biomedical Research Trust Fund would be established. Each year, revenues equivalent to a tax of one-half of one-percent on health insurance premiums and self-insured plans would be deposited into the Fund. The Secretary would make such funds available to medical schools, academic health centers, and others to support biomedical research projects.

Federal grants totaling \$35 million a year would be authorized to support the development and initial operation of non-profit, community-based staff and group model HMOs in underserved areas, including the development of managed-care programs in rural areas.

Additional grants would be authorized for innovative research and demonstration projects to establish telecommunications linkages between rural facilities and other medical facilities. Two million dollars of funds appropriated for the rural health transition grant program would be set aside for telecommunications projects.

A program to improve coordination of emergency medical services for rural areas would be authorized, including the establishment of an Office of Rural Emergency Services within HHS; funding of grants to State offices of rural emergency medical services; and assistance in the creation or enhancement of air medical transport systems. Authorization of appropriations of \$15 million for fiscal year 1996 and such sums as necessary for the years 1997 through 2000 would be provided for these activities.

The President would be authorized to conclude an agreement with Mexico to establish United States-Mexico Border Health Commission.

Title VIII. Medicare and Medicaid

A. Medicare Part C

A new Federal health insurance program would be established as of January 1, 1998, that would be called Medicare Part C. The Secretary, through the Health Care Financing Administration, the Social Security Administration, and other appropriate agencies would perform enrollment and eligibility functions necessary to administer the Medicare Part C program.

An individual would be eligible to enroll in Medicare Part C if: (1) the individual is a part-time, seasonal, or temporary employee; (2) the individual is a full-time employee in a firm with 100 or fewer employees that elects to cover employees under Medicare Part C, rather than a private plan; (3) the individual is not an employee; (4) the individual is a recipient of Aid to Families with De-

pendent Children (AFDC) or Supplemental Security Income (SSI); or (5) the individual meets the low-income eligibility criteria (specified in Title II) and is either not connected to the workforce or is employed by a firm with 100 or fewer employees.

Employers with 100 or fewer employees would be permitted to enroll employees and their dependents under Medicare Part C, unless the employer provides health insurance coverage under a private plan that meets defined Federal standards.

Medicare Part C benefits would be consistent with benefits provided under the guaranteed national benefit package. Additional benefits would be provided under Medicare Part C for eligible low-income individuals.

The Secretary would establish three premium structures: individual, single parent, and family coverage. The Secretary would compute premiums for Medicare Part C on a State-by-State basis. The premium for 1998 would be set in statute, but if necessary, would be modified by the Secretary to assure that premiums cover the full actuarial cost of benefits and all administrative costs.

A new Medicare Part C Trust Fund would be established, into which all premiums and State maintenance-of-effort payments would be deposited. Additional funds would be appropriated from general revenues to assure that funds are sufficient to cover low-income subsidies and supplemental low-income benefits, net of State maintenance-of-effort payments.

Payments for services provided under Medicare Part C would be consistent with the payment rates and methodologies specified under Medicare Parts A and B, with appropriate adjustments in payment amounts to reflect the population served by Medicare Part C.

Persons covered under Part C could elect to receive coverage through managed-care organizations that contract with Medicare under existing Medicare policies. The Secretary would make necessary changes to the adjusted average per-capita cost (AAPCC) for payments on behalf non-aged, Medicare Part C beneficiaries who elect to enroll in such plans.

Beginning January 1, 2001, Medicare Part C would make payments for emergency-care services provided to undocumented aliens.

B. Benefits for Low-Income Individuals

1. Low-income coverage

Low-income individuals who do not work or who work in firms with 100 or fewer employees, would be permitted to enroll in Medicare Part C or under a private plan offered by an employer.

Premium obligations for low-income individuals would be based on reported income. The premium obligation would be zero for individuals with income below the threshold amount specified under Title II (approximately 100 percent of the Federal poverty level) and for AFDC and SSI recipients. For other low-income individuals, the premium obligation would increase, on a sliding-scale basis.

Premium obligations for low-income workers would be reduced by any amount contributed by an employer. Low-income individuals

would be permitted to reflect the subsidies for which they are eligible by adjusting their tax withholding of their share of the premium obligation. The value of the premium would be capped at the lower of: (1) the subsidy amount for enrollment under Medicare Part C; or (2) the employee obligation under the plan offered by the employer.

A wrap-around benefit package would be provided under Medicare Part C for all low-income individuals with family income up to 100 percent of the Federal poverty level. All deductibles and copayments would be waived. All early and periodic screening, diagnostic, and treatment services (EPSDT) not otherwise covered in the guaranteed national benefit package would be covered for children up to age 18. Vision and hearing care, including eyeglasses and hearing aids, would be covered.

The wrap-around benefit package would also be provided under Medicare Part C for defined categories of individuals with income up to 200 percent of the Federal poverty level: pregnant women, children up to age 18, and AFDC and SSI recipients.

Low-income employees enrolled in private plans offered by employers would apply at local Social Security offices for premium-assistance certificates. Employees would transfer the certificate to their employer, and the employer would adjust premium obligations of the employees to the insurance company, net of premium subsidies provided. The Secretary would establish a procedure for payment of premium subsidies to private insurance plans offered by employers that enroll subsidy-eligible individuals.

Medicaid coverage of acute-care services would be repealed, effective upon the operation of the Medicare Part C program. Medicaid would continue to provide coverage to dually eligible individuals who exceed the limits under Medicare for inpatient mental health services. In addition, Medicaid would continue to cover long-term care, and other institutional services, including services for the mentally retarded and services provided in nursing facilities.

B. State Maintenance-of-Effort Payments

The Secretary would be prohibited from approving any change in a State's Medicaid program that would take effect prior to the implementation of Medicare Part C.

States would make maintenance-of-effort payments to Medicare Part C to partially offset the need for Federal subsidies of low-income individuals enrolled in Medicare Part C. For each State, a 1993-baseline level of Medicaid expenditures would be estimated for non-cash recipients (less Federal financial participation) of covered Medicare Part C services, including deductibles and co-insurance.

States would make per-capita payments to Medicare Part C for cash recipients (AFDC and SSI). These payments would be based on baseline per-capita Medicaid spending for services covered under Medicare Part C, made on behalf of AFDC families and SSI recipients under current law.

These baseline amounts would be updated by the Secretary, to 1998. In subsequent years, the non-cash-recipient amount would be updated by the allowable growth in per-capita spending in Medicare and growth in the general population under age 65. The per-

capita cash-recipient amount would be updated by the per-capita growth limit for Medicare.

The required State maintenance-of-effort obligation would be 100 percent of the sum of the cash and non-cash maintenance-of-effort amounts in 1998, 1999, and 2000, 96 percent in 2001 and 2002, and 86 percent thereafter. Increases in the maintenance-of-effort amounts would be limited to the allowed rate of growth in the Medicare program. Effective January 1, 2001, one percentage-point of the maintenance-of-effort amounts for States would be used to fund the additional costs incurred under Medicare Part C for providing emergency services to undocumented aliens after such date.

The Secretary would calculate the maintenance-of-effort obligations for Puerto Rico and other commonwealths and territories as if such commonwealths and territories were States. The reduction in maintenance-of-effort amounts due to treating these localities as States would be limited to the revenue collected as a result of the imposition of the tax on tobacco products in Puerto Rico.

C. Cost Containment in Medicare

1. Establishment of Medicare health expenditure estimates

As for the private sector, the Secretary would estimate total national health expenditures under Medicare Parts A through C, and the baseline rate of growth for future years. The estimates would include spending for all services covered under the national guaranteed-benefit package, supplemental policies, low-income wrap-around benefits, and related cost sharing.

The Medicare health spending estimates would be established on a per-capita basis and would be adjusted for shifts in enrollment between the public and private sectors. Target rates of growth would be set by statute for each year, beginning with 1996. The target rate of growth would be set so that the rate of growth in Medicare spending would be reduced by two-percentage points in 1996, and by an additional one-percentage point in each subsequent year until the rate of growth is slowed to the five-year average per-capita rate of growth in the GDP.

2. Allocation of national estimates to classes of services and States

The Medicare estimate of health spending would be allocated to various classes of health services and States using the same methodology used to allocate private-sector spending among classes and States. The Medicare estimate allocated to each State would be used to monitor the States' success in controlling health care costs. Health providers would report information to the Secretary to permit monitoring of health care spending within each State and class of service.

3. Medicare payment rates

Payments for services under Part C would be the same as the payment rates that would apply under Medicare Parts A and B. New codes and values, including separate diagnosis-related group (DRG) categories and weights for children, would be developed as needed so that these payment systems are appropriately adjusted

for services provided to patients under the age of 65. Annual updates in Medicare payment rates would be set to be consistent with Medicare's estimate of health spending.

In the case of services that are currently paid by Medicare on a cost-related basis, rate-of-growth limits would be imposed until prospective payment methodologies can be developed and implemented, by no later than January 1, 1997.

D. Additional Medicare Savings

1. Indirect medical education

The indirect medical education adjustment paid under the Medicare prospective payment system for both Medicare Part A and Medicare Part C, would be phased down beginning with the implementation of Medicare Part C. The formula factor would be reduced from 7.7 percent, to 6.8 percent for discharges occurring on or after January 1, 1998, through September 30, 1998. The formula factor would be reduced from 6.8 percent, to 6.0 percent for discharges occurring on or after October 1, 1998, through September 30, 1999. The formula factor would be reduced from 6.0 percent, to 5.2 percent for discharges occurring on or after October 1, 1999.

2. Disproportionate share adjustment

The disproportionate share adjustment paid under the Medicare prospective payment system for both Medicare Part A and Medicare Part C would be phased down beginning with the implementation of Medicare Part C.

Effective for discharges occurring on or after January 1, 1998, and before October 1, 1999, the Secretary would reduce payments that would otherwise be made under the disproportionate share adjustment by 25 percent. The reduction would be limited to 10 percent for urban hospitals with more than 100 beds and a disproportionate share patient percentage under the existing formula that is greater than 30 percent. Effective for discharges occurring on or after October 1, 1999, the Secretary would reduce payments that would otherwise be made under the disproportionate share adjustment by 50 percent. The reduction would be limited to 25 percent for urban hospitals with more than 100 beds and a disproportionate share patient percentage under the existing formula that is greater than 30 percent.

The Secretary would be directed to propose a modification to the definition of "disproportionate share patient percentage" in order to take into account the repeal of Medicaid and the establishment of Medicare Part C.

3. Payments for capital

Adjustments would be made to payments for inpatient-care hospital capital under Medicare, effective October 1, 1995. The Federal capital payment rate would be reduced by 7.31 percent. The hospital-specific capital payment rates would be reduced by 10.41 percent.

4. High-cost medical staffs

Limits would be established for Medicare payments for physician services relating to inpatient stays in acute-care hospitals.

5. Medicare secondary payer

Medicare secondary payer provisions scheduled to expire in 1998 would be extended. The existing data-match system, established to identify situations in which Medicare is secondary payer, would be extended. The application of Medicare secondary payer rules for disabled and end stage renal disease (ESRD) beneficiaries would be extended. A late penalty would be imposed on primary payers who delay reimbursing the Medicare program under the Medicare secondary payer provisions.

6. Home health services

A 20-percent coinsurance would be established for home health services provided under Medicare Parts A and B. Home health cost limits would be set at 100 percent of the mean per-visit cost to preserve savings resulting from the two-year freeze enacted in the Omnibus Budget Reconciliation Act of 1993 (OBRA '93).

7. Additional minor and technical amendments

The name of the Health Care Financing Administration would be changed to the Health Security Administration.

The Secretary would conduct demonstration projects relating to the transportation of patients, the treatment of diabetes and payments for comprehensive diabetes-management services.

Medicare payments to hospitals for hemophilia clotting factor would be extended through 1999.

Independent laboratories could provide clinical laboratory services to skilled nursing facilities.

The Secretary would be required to establish an expedited review process for review of payments to skilled nursing facilities for atypical services.

Additional minor and technical amendments to Medicare would be made, including those provisions that were dropped from the House-passed version of the OBRA '93, and are included in S. 1668.

Title IX. Quality and Consumer Protection

A. Quality Management and Improvement

The Secretary would establish standards for a National Quality Management Program and develop a set of national quality and performance measures which would apply uniformly to health plans, institutions, and health care professionals. A Health Care Advisory Commission would be appointed by the Secretary and would be required to make recommendations to the Secretary regarding the development and selection of national measures of quality performance. The national measures of quality performance would include the evaluation of outcomes, patient functional status, patient satisfaction, and risk management and reduction. In developing quality measures and clinical guidelines the Secretary would

be required to take into account criteria that are appropriate to rural clinical practice.

Federally qualified independent entities, through contracts with the Secretary would be responsible for ongoing profiling, pattern analysis, outlier identification, and application of practice guidelines and would be required to provide to enrollees a performance report. Health plans would be required to establish a grievance and appeal process and would be required to notify an enrollee of a decision on a claim within 30 days.

Individuals would be able to commence a civil action in an appropriate United States District Court or State court to obtain relief from antidiscriminatory activities. Reports by health plans to the Secretary regarding antidiscrimination requirements would be required to be collected using the least burdensome method identified by the Secretary. Privacy of information standards would apply to the disclosure of protected health information. The Health Care Advisory Commission would make recommendations to the Secretary regarding the development of additional standards for protected health information.

B. Information Systems and Administrative Simplification

Claims submitted by providers would be transmitted electronically using uniform formats to be developed by the Secretary. In developing a uniform coding system for procedures and diagnoses the Secretary would, to the maximum extent possible, use the Current Procedural Terminology (CPT). The Secretary would establish standards for the uniform claims no later than 18 months after the date of enactment. The provisions would be effective 12 months after the date the standards are established.

Each provider would be required to submit claims using a unique provider identification number. Each individual would be issued a uniform health security card.

The Secretary would develop standards for the uniform and electronic data set. The standards would be developed in consultation with the Health Care Advisory Commission and would, to the maximum extent practicable consistent with existing standards, including those set by the American National Standards Institute.

Administrative simplification provisions would provide reporting and coordination of benefits between all health insurance plans, including supplemental benefit policies and plans in States that opt out. The Secretary would be required to develop standards for an electronic, uniform hospital clinical data and patient-care information set. As a condition of Medicare participation, each hospital would be required to maintain hospital clinical data in electronic form. The Secretary could grant waivers for rural and small community hospitals.

C. Fraud and Abuse

The Secretary and the Attorney General would establish and coordinate an all-payer national health care fraud-control program.

The provisions under the Medicare and Medicaid programs which provide for civil monetary penalties and criminal penalties for specified fraud and abuse violations would apply to similar violations

for all payers in the national health care system. Current civil monetary penalties would be increased from \$2,000, to \$10,000. New civil monetary penalties would be established for certain activities, including kickback violations.

The current exception for discounts would be modified to prevent a provider of services from giving discounts in the form of a cash payment. An exception would be provided for the waiver or reduction of coinsurance if made pursuant to an established program, and applies to a defined group of individuals that are in financial need. A portion of the civil monetary penalties, fines, and damages assessed would be deposited in a fraud and abuse account. The assets in the account would be used to meet the operating costs of the national health care fraud and abuse control program and for such activities that are designed to educate providers about the fraud and abuse provisions.

The Secretary of Health and Human Services and the Attorney General would be required to issue advisory opinions on factual matters under the anti-kickback and self-referral statute. In addition, State laws which preclude entities from employing physicians would be preempted.

D. Physician Ownership and Referral

The physician ownership and referral ban would be extended beyond Medicare and Medicaid to all payers. The physician ownership and referral ban would be extended to cover home infusion therapy (excluding ambulatory infusion pumps) and any other item or service not rendered by the physician personally or by a person under the physician's direct supervision. The reference to "other diagnostic services" in current law would be deleted.

The exceptions in current law to the general ban on referrals would be continued with certain modifications. An exception would be provided for shared-facility services that meet certain requirements. The exception for rural providers would be modified to exempt entities providing 75 percent of their services to rural residents.

The in-office ancillary-service exception would be modified to require that solo practitioners furnish designated health services on wholly owned or exclusively leased equipment. The exception relating to group practices would be modified by deleting the requirement that services be provided in a centralized location.

Title X. Long-Term Care

A. Long-Term Care Program

The Secretary would establish a new long-term care program to provide home and community-based services for severely disabled persons of all ages and income. Four categories of disabled persons would be eligible for services: individuals requiring help with three or more activities of daily living, individuals with severe cognitive or mental impairment, individuals with severe or profound mental retardation, and severely disabled children under six years of age.

Individuals covered under the new program could receive the full range of home and community-based services. Services excluded

from coverage would include services furnished by a hospital, nursing facility, intermediate care facility or other institutional setting, and services covered under Medicare Parts A, B, or C. Services would be subject to cost-sharing, with no coinsurance, or nominal coinsurance imposed on individuals with income less than 150 percent of the Federal poverty level.

States would designate a State agency to manage and coordinate benefits under the new long-term care program. Each State would submit a plan that specifies how the State would perform these functions to the Secretary. The Secretary would be required to review and approve a plan submitted by the State for the administration of the new long-term care program prior to the allocation of Federal funds under this program. States would be permitted to contract with or establish local care coordination agencies throughout the State to assure the availability of home and community-based services for eligible individuals residing throughout the State.

The agency administering the home and community-based program could, in the case of services provided in a consumer-directed manner, arrange for an entity, other than the consumer or the individual provider, which would (i) inform recipients and providers of rights and responsibilities under all Federal labor and tax laws, and (ii) assume responsibility as the employer of the home care provider for effective billing, payments for service, tax withholding, unemployment, and workers' compensation. Service recipients would retain the right to select, hire, terminate, and direct the work of a home care provider.

Specified Federal funding levels would be established under this Act. A base allotment would be made to each State with an approved plan, without a requirement of State contributions. In addition to the base allotment, Federal payments to States would increase, on a sliding-scale basis, based upon the level of voluntary State contributions provided. A State that contributes the maximum contribution of 20 percent would be entitled to receive the full 80 percent Federal allocation. States would be required to maintain at least their current level of effort for home and community-based services, which would be indexed in future years.

Federal funding for the new long-term care program would be provided as follows: \$3 billion in fiscal year 2000, \$4 billion in fiscal year 2001, \$6 billion in fiscal year 2002, \$8 billion in fiscal year 2003, and \$10 billion in fiscal year 2004.

B. Federal Long-Term Care Insurance Standards

The Secretary would promulgate regulations to implement Federal standards for private long-term care insurance policies. States would enforce the standards for all long-term care insurance policies sold to individuals or employers. The Secretary would certify State compliance and would assume responsibility for enforcing the standards in a State that did not comply. Non-compliance by an individual or entity that markets a private long-term care insurance policy would be subject to a fine of up to \$10,000 per violation.

The Secretary, in consultation with the National Association of Insurance Commissioners (NAIC), would develop standardized formats and terminology to be used in long-term care insurance poli-

cies. Requirements relating to coverage would be established to clarify appropriate terms for coverage of benefits under policies. Restrictions on eligibility for benefits would be limited and clearly defined. Pre-existing-condition exclusions could be included only looking back six months for any previous illness or episode requiring treatment, and such exclusions could only continue for six months.

Requirements for inflation protection would be established. An insurer would be required to offer the purchaser the option to obtain coverage that protects benefit levels against the effects of inflation. The benefits under such a policy with inflation protection would increase by not less than five percent per year, compounded. Inflation protection would be excluded from the coverage only if the insured individual rejected in writing the option to obtain such coverage.

Non-forfeiture benefits would be required for all policies. The Secretary, in consultation with the NAIC, would promulgate regulations for an appropriate non-forfeiture benefit for policies that lapse.

Requirements relating to payment of benefits would be established. The issuer would provide for a procedure to determine whether threshold conditions for benefit eligibility would be met, based upon uniform assessment standards, procedures, and formats. Insurers would be required to provide an administrative procedure under which an individual could appeal any denial of a claim. In the event of a disagreement, the individual policyholder would be permitted to appeal an insurer's decision to the complaint review office established by the State (under Title IX).

Federal standards and provisions established under this Act would preempt State laws with respect to private long-term care insurance standards.

C. Miscellaneous

The number of authorized sites for PACE (The Program of All-Inclusive Care for the Elderly) would be increased from 15, to 30 sites.

Title XI. Revenue Provisions

A. Increase Excise Taxes on Tobacco Products

The excise tax on cigarettes would be increased by 45 cents per pack (for a total of 69 cents per pack), phased in over five years on the following schedule: 15 cents in 1995 and 1996, 25 cents in 1997, 35 cents in 1998, and 45 cents in 1999 and thereafter.

The excise tax on other tobacco products would be increased proportionately.

The increase in the Federal excise tax on tobacco products would apply to tobacco products manufactured and sold in Puerto Rico. The provision would be effective for products removed after July 31, 1995, with floor stocks taxes imposed on that and each subsequent tax-increase date.

B. Eliminate Exclusion for Employer-Provided Accident or Health Coverage Provided Through a Cafeteria Plan or Flexible Spending Arrangement

Effective January 1, 1995, accident or health benefits provided through a cafeteria plan or a flexible spending arrangement would not be excludable from an employee's income and wages for income and employment tax purposes. Transition relief, in the form of a delayed effective date, would be provided for (i) employees who receive such benefits under a collective bargaining agreement, and (ii) employees who are covered by a collective bargaining agreement and receive such benefits pursuant to a State, county, or municipal law.

C. Extend Medicare Coverage of, and Application of Hospital Insurance Tax to, All State and Local Government Employees

Medicare coverage would be extended on a mandatory basis to all employees of State and local governments not otherwise covered under present law, without regard to their dates of hire. Those employees and their employers would become liable for the hospital insurance tax and the employees would earn credit toward Medicare coverage. Employer and employee liability for the hospital insurance tax would be phased in equally over a four-year period beginning in 1997.

D. Increase Deduction for Health Insurance Costs of Self-Employed Individuals

Self-employed individuals would be allowed to deduct a portion of health insurance premiums they pay for coverage for themselves and their families. Until December 31, 1993, a deduction of up to 25 percent of such premiums was allowed, but this deduction expired on that date. The 25-percent deduction would be reinstated for the period January 1, 1994, through December 31, 1997. Beginning January 1, 1998, an 80-percent deduction would be allowed.

E. Tax Treatment of Organizations Providing Health Care Services and of Related Organizations

1. Requirements for Tax-Exempt Health Organizations

Organizations which are exempt from tax under sections 501(c)(3) or 501(c)(4) of the Internal Revenue Code (the Code) and which have as their predominant activity the provision of health care services would be required to do the following, in addition to satisfying a community benefit standard: (1) provide significant qualified outreach services; (2) assess annually the community's needs and develop a written plan stating how the organization plans to meet those needs; (3) not discriminate in providing health care on the basis of whether an individual is insured by a government-sponsored health plan; (4) if the organization provides emergency health care services, not discriminate in providing these services on the basis of the patient's ability to pay; (5) to the extent of its financial ability, provide non-emergency health care without

regard to the patient's ability to pay; and (6) maintain an independent board of directors.

With respect to the non-discrimination requirement relating to government-sponsored health plans, the Internal Revenue Service (IRS) would be authorized to create a safe harbor for nursing homes accepting a high proportion of Medicaid patients.

Organizations that fail to satisfy any of the new statutory requirements would be subject to intermediate sanctions in the form of penalty excise taxes that IRS could impose in lieu of revocation.

Organizations would be required to make available to the general public the written community-needs and outreach-services plan, as well as copies of the organization's Form 990 for the past three years. In addition, organizations would be required to report on the Form 990 excise taxes assessed due to violations of the qualifications for tax exemption (including the new statutory requirements for health care organizations and excess benefit transactions). Additional reporting and public disclosure would apply to health care.

The new statutory requirements would be effective January 1, 1995, except the independent governance requirement would be effective January 1, 1997.

2. HMO Qualification under code section 501(c)(3) or (4)

HMOs seeking tax-exempt status under Code section 501(c)(3) would be required to be a "staff" or "dedicated-group" model HMO. The exception for tax-exempt HMOs from the commercial-type insurance rules of Code section 501(m) would be clarified to define non-commercial-type insurance. Accordingly, HMOs seeking tax-exempt status under Code section 501(c)(4) would be treated as not providing commercial type insurance only if primary care is provided to members by health care professionals who have assumed substantially all of the risk with respect to the rates of utilization. The provision would be effective on the date of enactment.

3. Regional alliances and certain parent organizations

A regional health alliance created by a State or local government would be eligible for Federal tax-exempt status. In addition, parent holding companies for hospitals or medical research organizations may qualify as public charities. Both provisions would be effective on the date of enactment.

4. Private inurement and intermediate sanctions

Organizations seeking exemption under Code section 501(c)(4) which have as their predominant activity the provision of health care services, would qualify only if no part of the net earnings of such organizations inures to the benefit of any private shareholder or individual.

Intermediate sanctions in the form of excise tax penalties could be imposed when a health care organization exempt under Code section 501(c)(3) or (4) engages in an "excess benefit transaction" defined as a non-fair market-value transaction, including the payment of unreasonable compensation, and an income-sharing transaction prohibited under present law. In addition, a loan to an orga-

nization manager would be treated as an excess benefit transaction.

The sanctions would be imposed on disqualified persons ("insiders") who benefit from such improper transactions, and on organization managers who participate in a transaction knowing that it was improper. There would be no intermediate penalty tax on the tax-exempt entity.

These provisions generally would be effective on the date of Committee action.

5. Taxable property and casualty insurance companies

The bill would expand the scope of organizations treated as taxable property and casualty insurance companies to include organizations operating as an HMO or entering into arrangements under which fixed payments or premiums are received by the organization for providing health care services. Blue Cross/Blue Shield organizations would retain their current tax treatment. The provisions generally would be effective for taxable years beginning after December 31, 1994.

F. Tax Treatment of Accelerated Death Benefits Under Life Insurance Contracts

Certain amounts received under a life insurance contract would be excluded from gross income if the insured person is terminally ill, generally effective for amounts received after the date of enactment.

G. Definition of Employee

The Department of the Treasury would be directed to submit a legislative proposal relating to the classification of workers as employees or independent contractors to the House Committee on Ways and Means and the Senate Committee on Finance before January 1, 1996.

H. Increase Penalties for Failure to File Correct Information Returns with Respect to Non-Employees

The penalty for failure to file correct information returns under Code sections 6041 and 6041A with respect to payments for services would be increased to the greater of \$50.00 for each return or five percent of the amount required to be reported correctly but not so reported. An exception to this increase would be provided where there has been substantial compliance. In such a case, the present-law penalty of \$50.00 for each return would continue to apply.

I. Limitation on Prepayment of Medical Insurance Premiums

Amounts paid during a taxable year which are allocable to insurance coverage or medical care to be provided more than 12 months after the month in which the payment is made would be treated as paid ratably over the period during which the coverage or care is to be provided. The proposal would apply to amounts paid after December 31, 1994.

J. Tax Treatment of Funding of Retiree Health Benefits

An employer would be permitted to fund the cost of post-retirement medical and life insurance coverage through deductible contributions to a welfare benefit fund, if such funding is on a level basis over the working lives of covered employees, but not over a period of less than 10 years. Also, the prefunding of post-retirement medical and life insurance benefits would be required to be maintained as a separate account under the fund, effective for contributions after the date of enactment.

K. Excise Tax on Health Insurance Premiums and Health Expenses of Self-Insured Plans

An excise tax of two percent would be imposed on costs of providing health coverage. In the case of indemnity insurance plans, the tax would be imposed on premiums. In the case of self-insured health plans, the tax would be imposed on health care expenditures and administrative expenses. In the case of prepaid health plans, the tax would be imposed on the fixed payments or premiums paid by members of the plans. The tax would be effective for premiums paid or expenses incurred after December 31, 1995.

Portions of the net revenue collected from the excise tax on health premiums and expenses would be dedicated to four different trust funds for health-related purposes. The Health Work-force Trust Fund would receive net revenues equivalent to a tax of one percent of the revenue to make payments to hospitals for the direct and indirect costs of graduate medical education. The Undergraduate Medical Education Trust Fund would receive \$50 million per year that would be available to certain medical schools if they actively recruit minority students and maintain programs that encourage students to choose primary-care residency training. The Lead Abatement Trust Fund would receive \$500 million annually to fund Federal grants to State and local governments for the purpose of reducing the risk of lead paint exposure. The Biomedical Research Trust Fund would receive net revenues equivalent to a tax of one-half of one percent to support biomedical research at medical schools, academic health centers, and other institutions.

L. Extension of the Rules Applicable to Certain Blue Cross and Blue Shield Organizations to Certain Other Organizations

The special deduction and other rules contained in Code section 833 which are applicable to certain Blue Cross and Blue Shield organizations would be extended to certain similarly situated organizations, effective for taxable years beginning after 1986.

M. High-Risk Insurance Pools

Certain high-risk health insurance pools would be eligible for tax exemption under Code section 501(c), applicable to taxable years beginning after December 31, 1989, and ending on December 31, 1997.

N. Tax Incentives for Health Professionals Who Locate in Underserved Areas

Health care professionals who locate their practices in medically underserved areas would be allowed two special tax benefits.

Primary care physicians who begin or relocate their practices in medically underserved areas would be allowed a nonrefundable income tax credit of \$1,000 per month for up to 60 months. A credit rate of \$500 per month would be allowed for nurse-practitioners, certified nurse-midwives and physicians' assistants. The credit would be available for taxable years beginning after 1994.

Current tax law (Code section 179) allows \$17,500 in depreciable business equipment to be expensed (rather than depreciated) if the taxpayer's annual investment in such property does not exceed \$200,000.

For medical equipment owned and used by a primary-care physician in an underserved area, the amount allowed to be expensed would be increased in an underserved area by either \$10,000 or the cost of such property, whichever is smaller. The higher expensing amount would be available for property placed in service in taxable years beginning after 1994.

O. Tax Treatment of Medical Savings Accounts

Rules governing the tax treatment of, and contributions to, medical savings accounts (established in Title II of the bill) would be provided. Employers could make deductible contributions to medical savings accounts, up to a specified amount. Such contributions would be excludable from the employee's income. Earnings on these accounts would be currently taxable to employees. Withdrawals for medical expenses (with the exception of the employee's premium expenses) would not be taxed.

III. EXPLANATION AND JUSTIFICATION

Title I. Health Care Security

Sec. 1. Universal Coverage

Present Law.—No provision.

Explanation of Provision.—Every eligible individual would be entitled to the benefits of the guaranteed national benefit package, described in Title III. Every eligible individual would be entitled to a health security card, which would be issued by the health plan in which the individual, or the individual's family, enrolls.

An eligible individual would be defined to include any individual who is (i) a citizen or national of the United States, (ii) an alien permanently residing in the United States under color of law, or (iii) an alien in the United States as a long-term non-immigrant. Undocumented aliens would not be considered eligible individuals.

Aliens permanently residing under color of law would include the following classes of individuals: (i) permanent resident aliens; (ii) refugees; (iii) asylees or aliens whose deportation has been withheld because of prospective persecution abroad; (iv) aliens granted temporary residence under the Immigration Reform and Control Act of 1986 (IRCA) legalization programs for long-term residents

and special agricultural workers; (v) aliens paroled into the United States for an indefinite period of time under the Attorney General's parole authority or granted extended voluntary departure as a member of a nationality group; and (vi) immediate relatives of United States citizens with pending applications for permanent residency.

The other class of aliens that would be eligible for benefits are long-term non-immigrants, which would be defined to include: (i) traders or entrepreneurs authorized under a treaty between the United States and the aliens' homeland (E visas); (ii) workers in temporary positions as nurses, in specialty occupations, in agricultural or other labor, or as trainees (H visas); (iii) foreign media representatives (I visas); (iv) fiancées of United States citizens (K visas); (v) managers, employees with specialized knowledge, or executives of multinational corporations (L visas); (vi) immediate relatives of certain former or long-term employees of an international organization (N visas); (vii) performers with extraordinary ability in an artistic, scientific, educational, business, or athletic field (O visas); (viii) participants in international cultural exchange programs approved by the Attorney General (Q visas); and (ix) temporary religious workers (R visas). Non-immigrants who would be considered ineligible for benefits would include academic students (F visas), tourists and business visitors (B visas), and visiting artists and entertainers (P visas).

The Secretary of Health and Human Services (hereafter referred to as the Secretary), in consultation with the Attorney General, would make recommendations to the Congress with respect to classes of eligibility and modifications of eligibility and coverage rules. In addition, the Secretary would consider appropriate treatment of diplomatic personnel and employees of international organizations, appropriate rules for eligible minors who are not dependents of eligible individuals, and appropriate rules for the treatment of eligible spouses who are dependents of ineligible individuals. The Secretary, in consultation with the Attorney General, would consider proposals for reciprocal agreements between the United States and other foreign governments with respect to coverage of non-immigrants, and would make recommendations, as appropriate, to the Congress.

An individual entitled to benefits under the current Medicare program would retain coverage under the program, and the provision of benefits under Medicare Part A would be deemed to constitute an entitlement to the benefits covered under the guaranteed national benefit package.

Prisoners who are imprisoned by Federal, State or local authorities following conviction as adults would not be considered eligible individuals during the term of imprisonment.

Effective Date.—January 1, 1998.

Sec. 2. Protection of Consumer Choice

Present Law.—No provision.

Explanation of Provision.—Nothing in this Act would prohibit an individual from choosing his or her own health care provider. Nothing in this Act would prohibit an individual from purchasing any health care services. Nothing in this Act would prohibit an individ-

ual from purchasing supplemental insurance, consistent with the requirements in Title V of this Act, to cover health care services that are not included under the guaranteed national benefit package. Nothing in this Act would prohibit employers from providing coverage of benefits in addition to benefits covered under the guaranteed national benefit package, consistent with the requirements of this Act.

Effective Date.—January 1, 1998.

Title II. Individual and Employer Responsibilities

Subtitle A. Individual responsibilities

Sec. 1. General Individual Responsibilities

Present Law.—There is currently no requirement that individuals obtain health insurance.

Explanation of Provision.—Beginning in 1998, every lawful resident of the United States generally would be required to obtain health insurance providing a standard set of benefits. Individuals generally would be required to enroll in either a qualified health plan or in the Medicare Part C program. (The provisions describing the establishment of the Medicare Part C program are set forth in Title VIII of the bill). There would be three classes of enrollment: individual, single-parent, and family. In the case of a married couple, each spouse could enroll in a separate plan, or they could enroll in the same plan.

An individual would be deemed to be enrolled in Medicare Part C for any month in which the individual, or any young dependent of the individual, is not covered under a qualified health plan. A qualified health plan would be one which meets the standards specified in Title V of the bill. Individuals could either enroll in a qualified health plan provided by their employer (as described in Subtitle B of this title) or purchase one directly from an insurance company. Individuals who receive benefits under certain governmental programs (for example, active duty military personnel and individuals enrolled in Medicare Part A) would be deemed to be enrolled in a qualified health plan for this purpose.

Employers generally would be required to pay 80 percent of the applicable premium for each employee, and could pay more than 80 percent on an elective basis. Individuals generally would be required to pay any portion of the premium not owed or paid by their employers. Certain low-income individuals would be entitled to subsidies to reduce the amount of premiums that would otherwise be owed.

Effective Date.—January 1, 1998.

Sec. 2. Individual Share of Gross Medicare Part C Premiums

Present Law.—(a) In General.—No provision.

(b) Taxpayers filing joint returns.—No provision.

(c) Taxpayers not filing joint returns.—No provision.

Explanation of Provision.—(a) In General.—For any month in which an individual, or any young dependent of the individual, is not covered under a qualified health plan, the individual share of the Medicare Part C premium would be calculated and reported on

the annual individual Federal income tax return. Generally, individuals not required to file a tax return would not owe Medicare Part C premiums. If a taxpayer (or any young dependent of the taxpayer) is not covered by a qualified health plan for any month during the taxable year, the taxpayer would be required to calculate his or her gross Part C premium for those months. In the case of any taxpayer who is covered by a qualified health plan or whose young dependent is so covered, the taxpayer would be required to furnish certification of such coverage by attaching to the tax return a written statement issued by the employer or health plan setting forth the months of coverage and identifying all covered individuals, or in such other time and manner as the Secretary of Treasury may prescribe.

A taxpayer would determine his or her gross monthly premium under tables prescribed by the Secretary of Health and Human Services (HHS). These tables would distinguish three separate classes of enrollment: individual, single-parent, and family. The gross Medicare Part C premium for a particular taxpayer would be based on the taxpayer's class of enrollment and the State in which the individual has his or her principal place of abode for the first day of the month. The Secretary of Treasury could prescribe regulations to provide guidance in determining the applicable family premiums in the case of spouses who reside in different states.

(b) Taxpayers filing joint returns.—If neither taxpayer is covered under a qualified health plan for the month, and either taxpayer has a young dependent as of the beginning of that month who is not covered by a qualified health plan, the gross Part C premium for taxpayers filing joint returns that month would be the family premium. If only one of the taxpayers is covered by a qualified health plan, and either taxpayer has a young dependent as of the beginning of that month who is not covered by a qualified health plan, the gross Part C premium for that month would be the single-parent premium. If the taxpayers have no young dependents, or have only young dependents who are covered by a qualified health plan, the gross monthly premium would be the individual premium for each spouse not covered by a qualified health plan for the month. The foregoing rules would apply regardless of whether the taxpayers were married for the entire year or only a portion of the year.

(c) Taxpayers not filing joint returns.—If the taxpayer has a young dependent as of the beginning of the month who is not covered by a qualified health plan, the gross premium for taxpayers not filing joint returns that month generally would be the single-parent premium. However, if the taxpayer was married at any time during the year, a special rule would apply. If either spouse has a young dependent as of the beginning of any month who is not covered by a qualified health plan, the Part C premium for that month would be one-half the family premium. The foregoing rule would apply to all months during the taxable year, regardless of whether the taxpayer was married for the entire year or only a portion of the year.

If the taxpayer has no young dependents, or has only young dependents who are covered by a qualified health plan, the gross monthly premium would be the individual premium.

Effective Date.—January 1, 1998.

Sec. 3. Net Part C Premium Liability

Present Law.—No provision.

Explanation of Provision.—The net Part C premium liability owed by any taxpayer would be equal to the gross Part C premium (calculated as described above), less mandatory employer contributions owed by the employer on the taxpayer's behalf (including mandatory contributions from former employers), elective employer contributions, and any applicable low-income subsidies. The amounts of an employer's mandatory and elective contributions would be reported on the employee's annual W-2 form, which would be attached to his or her tax return. The amount of mandatory employer contributions that a taxpayer could use to offset his or her Part C premium obligation would be limited to 80 percent of the gross Part C premium.

An individual who is married at any time during the year but does not file a joint return could allocate all or a portion of his or her employer's contribution to the other spouse under conditions that the Secretary of Treasury may prescribe.

Effective Date.—January 1, 1998.

Sec. 4. Payment for the Individual Share of Premiums

Present Law.—No provision.

Explanation of Provision.—An individual who is covered under Medicare Part C would be required to make Part C premium payments during the year through employee withholding, estimated tax payments, or payments to the Secretary of HHS. Employers would collect and remit the individual share of their employees' Part C premiums to the Internal Revenue Service by adjusting the amount of income tax withheld during the year. Generally, non-employees such as independent contractors and other self-employed individuals, unemployed individuals, and other individuals outside the work force could either pay Medicare Part C premiums to the Internal Revenue Service through the existing estimated tax system or to the Secretary of HHS under a system to be established by such Secretary. Such payments to HHS would be treated as estimated tax payments.

A taxpayer who underpays his or her combined liability for Federal income taxes and Medicare Part C premiums would be subject to the existing penalties for the underpayment of Federal income tax. Estimated tax penalties would not be applicable, however, to any underpayment of Medicare Part C premiums resulting from an individual's involuntary loss of employment. A taxpayer who overpays his or her combined liability for Federal income taxes and Medicare Part C premiums would be eligible for a Federal income tax refund.

For individuals who receive coverage through a qualified employer health program, the employer would be required to withhold the individual's share of premiums and remit them to the insurer.

Effective Date.—January 1, 1998.

Sec. 5. Low-income Subsidies

Present Law.—(a) Individuals enrolled in Medicare part C.—No provision.

(b) Individuals enrolled in qualified health plans.—No provision.

Explanation of Provision.—(a) Individuals Enrolled in Medicare Part C—In general, any individual who is not required to file a tax return under present law would not be required to pay a Medicare Part C premium. Taxpayers having modified adjusted gross income below a threshold amount would have no Part C premium obligation. In addition, any taxpayer receiving assistance under Aid to Families with Dependent Children or Supplemental Security Income (including individuals described in section 1619(b) of the Social Security Act) for all twelve months of the taxable year would have no Medicare Part C premium obligation.

The threshold amounts (in 1994 dollars, indexed annually for inflation) would be: \$7,400 for a household of one; \$11,500 for a household of two or three; and \$16,000 for a household of four or more. Household sizes would be based on the number of personal exemptions allowable to be claimed on the tax return. Modified adjusted gross income would be adjusted gross income increased by tax-exempt interest and excluded foreign and possession source income and determined without regard to carrybacks and carryovers from other taxable years. The threshold amount would be zero for married individuals filing separate returns, unless the individual lived apart from his or her spouse at all times during the last six months of the taxable year.

The subsidy would be phased out as modified adjusted gross income increases above the threshold amount. For taxable years ending in 1998, 1999, or 2000, the subsidies would be ratably phased out between the threshold amount and 200 percent of the threshold amount. In 2001 and 2002, the subsidies would be ratably phased out between the threshold amount and 220 percent of the threshold amount. In 2003 and thereafter, the subsidies would be ratably phased out between the threshold amount and 240 percent of the threshold amount.

The employer requirement to pay Part C premiums on behalf of its employees would not be affected by an employee's eligibility to receive low-income subsidies.

(b) Individuals enrolled in qualified health plans.—A low-income individual enrolled in a qualified health plan would be required to submit an application to the Secretary of HHS to obtain a subsidy for the individual portion of his or her health care premium. Such subsidies would be administered by the Secretary through a premium certificate program (as described in Title VIII of the bill).

Effective Date.—January 1, 1998.

Sec. 6. Residents of U.S. Possessions

Present Law.—No provision.

Explanation of Provision.—Individuals residing in Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands would be entitled to receive benefits under the Medicare Part C program only if the possession in which they reside meets certain requirements. In order to meet the require-

ments, the possession would be required to enter into an agreement with the United States pursuant to which it would satisfy a number of conditions. The possession would impose a tax on its residents, equivalent to the tax described above, to collect the individual share of Part C premiums. The possession could not reduce or rebate in any way, directly or indirectly, any individual's liability to the possession under the equivalent tax. The possession also would be required to remit the amount of taxes so collected to the U.S. Treasury, and meet other requirements prescribed by the Secretary of the Treasury and the Secretary of HHS. A bona fide resident of a possession that meets the above requirements generally would be exempt from liability to the United States for the individual share of Part C premiums. These requirements are described in more detail in Title VIII.

Effective Date.—January 1, 1998.

Sec. 7. Exemptions

Present Law.—(a) Young dependents.—No provision.

(b) U.S. citizens and residents living abroad.—No provision.

(c) Nonresident aliens.—No provision.

(d) Individuals receiving other governmental health coverage.—No provision.

(e) Members of certain religious faiths; qualified disabled veterans.—No provision.

Explanation of Provision.—(a) Young dependents.—A young dependent would have no Part C premium obligation. A young dependent would be an individual under 19 years of age (under 24 in the case of a full-time student) for whom another individual is allowed to claim a personal exemption for the taxable year.

(b) U.S. citizens and residents living abroad.—Any U.S. citizen or resident who, for the entire taxable year, meets the definition of a qualified individual under the foreign earned income exclusion (as set forth in Code section 911(d)(1)) by reason of living abroad would not be treated as a Medicare Part C covered individual for any month during the taxable year, unless the individual received services under Medicare Part C during the taxable year. A qualified individual for this purpose generally would be one whose tax home is in a foreign country, and who either (1) is a bona fide resident of a foreign country for an uninterrupted period including an entire taxable year, or (2) is physically present abroad for at least 330 full days during any 12 consecutive months.

If an individual qualifies for the section 911 exclusion during only a portion of the taxable year, the exemption from Medicare Part C premium liability would apply only for months that begin during the portion of the year when the individual qualifies for the section 911 exclusion. For example, assume that as of January 1 a U.S. citizen resides in the United States and is liable for Medicare Part C premiums, but leaves the country on March 15 and becomes a qualified individual under section 911 for the period starting on that date and continuing into the next year. Under the bill, the individual would owe three months of Part C premiums in the year of departure. As another example, assume that from January 1 through November 14, a U.S. citizen qualifies for the section 911 exclusion, and that the individual moves back to the United States

on November 15. Under the bill, the individual would owe one month's Part C premium in the year of return (assuming no other exemption applies).

The Secretary of Treasury, after consultation with the Secretary of HHS, could establish regulations under which health plans of foreign governments or foreign employers outside the United States could be treated as qualified health plans for purposes of exempting an individual from Medicare Part C liability, and provide for appropriate adjustments to the rules for certifying coverage under such plans.

(c) Nonresident aliens.—Under the bill, nonresident aliens generally would be ineligible for Medicare Part C benefits, and would have no Part C premium obligation. For this purpose, the term “nonresident alien” would be defined as under present law in Code section 7701(b).

(d) Individuals receiving other governmental health coverage.—For any month in which an individual is entitled to receive benefits under certain governmental health programs, the individual would be deemed to be enrolled in a qualified health plan and thus would have no Medicare Part C premium obligation. These individuals would include active duty military personnel, persons receiving Medicare Part A benefits, individuals participating in a State benefit management program (as defined in Title IV of the bill) and prisoners.

(e) Members of certain religious faiths; qualified disabled veterans.—Members of certain religious faiths could apply to the Secretary of HHS for an exemption from liability for Part C premiums in a manner similar to that used for the present-law exemption from self-employment taxes under Code section 1402(g). Members of a recognized religious sect (or division of a sect) that is opposed to the acceptance of the benefits of any private or public insurance that makes payments toward the cost of, or provides services for, medical care could apply for an exemption from liability for Part C premiums if they waive their right to receive benefits under the Medicare Part C program.

Veterans entitled to receive benefits under 38 U.S.C. section 1710(a)(1) could similarly apply to the Secretary of HHS for an exemption from liability for Part C premiums by waiving their right to receive benefits under the Medicare Part C program. Such exemption would be effective as of the first day of the month following the month in which the exemption is requested. The exemption would be effective until terminated by the individual upon notice to the Secretary of HHS. Such termination would be effective as of the first day of the month following the month in which such notice is given. In no event could any exemption or termination be effective for less than a period of one year. ◊

Effective Date.—January 1, 1998.

Subtitle B. Employer responsibilities

Sec. 8. Employer Premium Contributions

Present Law.—(a) In general—There is currently no requirement that employers provide or contribute toward the health insurance coverage of their employees. However, employers who do provide

health insurance coverage to their employees must allow health plan participants the opportunity to continue their coverage in the employer's health plan for a specified period of time after the occurrence of certain qualifying events (such as termination of employment) that otherwise would have terminated such coverage. The health care continuation rules are commonly referred to as the "COBRA" rules because they were enacted as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

(b). Employer contributions for employees enrolled in Medicare part C.—No provision.

(c) Class of enrollment.—No provision.

(d) Payment of the employer share of part C premiums.—No provision.

(e) Overpayments resulting from incorrect information on employee withholding certificates.—No provision.

(f) Employer contributions toward qualified health plans.—No provision.

(g) Elective employer contributions.—No provision.

(h) Full-time employment; part-time employment.—No provision.

Explanation of Provision.—(a) In general.—Employers generally would be required to pay 80 percent of the applicable health premium for each employee, based on the category of health plan in which the employee is enrolled, the employee's State of residence, and the employee's class of enrollment. Employers would be permitted to make elective contributions in excess of the mandated 80 percent, subject to certain nondiscrimination rules. Employers would be required to withhold from the employee's wages any portion of the premium not paid by the employer (net of any applicable low-income subsidies).

Employer premium contributions would be paid to either (1) a qualified health plan, or (2) Medicare Part C. Large employers (those employing more than 100 employees) would be required to cover their employees under qualified health plans. Small employers could offer their employees coverage under either qualified health plans or Medicare Part C. Employers would be required to make a monthly premium contribution for each employee for each month in which the employee is employed by the employer as of the first day of the month.

Employer contributions would be reduced proportionally in the case of an employee who works less than 35 hours per week. However, no monthly employer contribution would be required with respect to any employee whose wages do not exceed \$100 in a given month.

(b) Employer contributions for employees enrolled in Medicare part C.—For any employee enrolled in Medicare Part C, the required employer contribution would be equal to 80 percent of the applicable Medicare Part C premium for the employee's class of enrollment and State of residence, reduced proportionally in the case of an employee who works less than 35 hours per week. An employee's enrollment status and State of residence would be determined based on information on the withholding certificate supplied by the employee, unless the employer has actual knowledge that the information provided on the certificate is incorrect. As under present law, the employer generally may rely on the information contained

in the employee's withholding certificate, and would not be subject to penalties for so relying. The applicable premium for each State and each class of enrollment would be determined under tables prescribed by the Secretary of Health and Human Services (HHS).

If an employee's family status changes (for example, if the employee gets married or has a child), the employee would be required to submit a new withholding certificate to his or her employer within ten days. The employer contribution for any month would be based on the withholding certificate in effect as of the first day of that month.

(c) Class of enrollment.—There would be three classes of enrollment: individual, single-parent, and family.

Unless the withholding certificate states to the contrary, the employer contribution would be based on the individual Medicare Part C premium.

If the withholding certificate states that the employee is married and has a young dependent not covered by a qualified health plan, the applicable premium would be determined as follows. If the employee's spouse is covered by a qualified health plan, the employer contribution would be based on the single-parent premium. If the employee's spouse is not covered by a qualified health plan, the employer contribution would be based on the family premium. If, however, the employee certifies that another employer (either another employer of the employee, or an employer of the employee's spouse) is paying at least 80 percent of the family Part C premium for the employee's family, the applicable Medicare Part C premium would be zero, but the employer would be required to make a non-enrolling employer payment with respect to that employee (as described below).

If the employee is not married, but has a young dependent not covered by a qualified health plan, the employer contribution would be based on the single-parent premium.

If the employee is married, but has no young dependents, or has only young dependents who are covered by a qualified health plan, the employer contribution would be based on twice the individual premium (to cover both the employee and the employee's spouse). If, however, the employee certifies that at least 80 percent of the individual premium is being paid by an employer of the employee's spouse (either to Medicare Part C or to a private qualified health plan), the employer contribution would be based on the individual premium.

If the withholding certificate states that the employee is a young dependent, no employer contribution would be required.

An employee would be treated as unmarried for purposes of determining the required employer contribution if the employee's spouse is exempt from Part C liability under the exemption for (1) members of certain religious faiths, (2) qualified disabled veterans, or (3) prisoners. The requirements for each of these exemptions are described in detail in Subtitle A of this title, "Individual Responsibilities".

(d) Payment of the employer share of part C premiums.—Employer contributions toward Medicare Part C coverage would be paid in the same manner as existing employment taxes (such as Social Security taxes) are paid, and an employer's failure to pay

such premiums would subject the employer to existing penalties for failure to pay employment taxes. Present-law administrative and judicial appeals procedures that apply to employment taxes would also apply with respect to Part C premiums. For each employee enrolled in Medicare Part C, an employer would be required separately to report on the employee's Form W-2 the total amount of required employer contributions and elective employer contributions made toward Medicare Part C coverage.

(e) Overpayments resulting from incorrect information on employee withholding certificates.—If an employer determines, on or before January 31 of any year, that it overpaid Medicare Part C premiums in the preceding calendar year as the result of incorrect information on any withholding certificate in effect for any month during that year, the employer could credit the amount of overpayment toward its future employment tax liability. The employer would be required to confirm its determination with an amended W-4 from the employee or other appropriate documentation. In such cases, the employer would be required to report the correction on the Form 941 filed by the employer for the final calendar quarter of the preceding year, and the employee's Form W-2 for the preceding year must reflect the corrected amount.

(f) Employer contributions toward qualified health plans.—For employees enrolled in qualified health plans provided by the employer, the required employer contribution would vary based upon the type of plan selected by the employee. The amount of required contribution for each type of plan is described below in Section 13 of this Subtitle.

(g) Elective employer contributions.—Employers would be permitted to make elective contributions toward the health coverage of their employees in excess of the required premium amount, as long as certain nondiscrimination rules are satisfied. The nondiscrimination rules are described below in Section 14 of this Subtitle.

(h) Full-time employment; part-time employment.—In the case of an employee who works less than 35 hours per week, the required employer contribution would be based on the ratio of the number of hours in the employee's normal work week to 35 hours.

Educational employees and other individuals employed in industries where a normal work week consists of less than 35 hours per week would be treated as full-time employees under the bill if they work the customary hours that constitute full-time employment in that industry. Educational employees would also be considered to be employees for periods between two academic years (and an employer contribution would be required with respect to such periods) if the individual was employed by the employer for the first academic year and there is a reasonable assurance that the individual also will be employed by the employer in the second academic year.

Effective Date.—The provisions would be effective for large employers as of January 1, 1996, and for small employers as of January 1, 1998.

Sec. 9. Non-enrolling Employer Payments

Present Law.—No provision.

Explanation of Provision.—If an employee declines coverage under the employer's qualified health plans, and the employee is not enrolled in Medicare Part C (i.e., the employee is enrolled in another qualified health plan, such as a spouse's employer's plan), the employer (the "non-enrolling employer") would be required to make a non-enrolling employer payment with respect to that employee. Non-enrolling employer payments also would be required with respect to any employee enrolled in Medicare Part C who certifies that another employer (either another employer of the employee, or an employer of the employee's spouse) is paying at least 80 percent of the family Part C premium for the employee's family.

The non-enrolling employer payment with respect to any employee would be equal to 80 percent (reduced proportionally in the case of part-time employees) of the individual Part C premium for the State in which the employee is principally employed. As described below, a portion of the aggregate amount of such payments would be distributed to employers who provide family coverage to their employees by providing a credit based on the amount of family premiums paid by such employers.

No non-enrolling employer payments would be required with respect to the employment of any exempt employee.

Effective Date.—January 1, 1998.

Sec. 10. Family Premium Credit

Present Law.—No provision.

Explanation of Provision.—Employers would be eligible for a tax credit equal to a percentage of the total amount of family premiums paid by an employer on behalf of its employees. Premiums paid toward single-parent coverage would not be eligible for the credit. Such credits would be taken against an employer's employment tax liability. An employer's deduction for providing health insurance would be reduced by the amount of the credit.

The total amount of family premiums paid by an employer would be determined as follows. For any employee receiving family coverage under Medicare Part C, the actual amount of mandatory employer contributions paid by the employer toward that employee's family coverage would be included. For employees receiving family coverage under an employer's qualified health plans, an imputed Part C family premium would be computed. The imputed Part C premium would be equal to 80 percent (reduced proportionally in the case of part-time employees) of the family Part C premium for the State in which the employee is principally employed. The total amount of family premiums eligible for the credit would be equal to the sum of: (1) the mandatory Part C payments made for each employee receiving family coverage under Medicare Part C, and (2) the imputed Part C premium for each employee receiving family coverage under qualified health plans provided by the employer.

The total amount of family premiums eligible for the credit would be multiplied by the credit percentage to determine the amount of the employer's credit.

The credit percentage applicable for each calendar year would be determined by the Secretary of Treasury, in consultation with the Secretary of HHS, based upon the aggregate amount estimated to be collected from non-enrolling employers (as described above). The

family premium credit would be phased in between 1998 and 2001, with employers providing family coverage receiving 25 percent of the aggregate funds estimated to be collected from non-enrolling employers in 1998 and 1999, 40 percent in 2000, 60 percent in 2001, and 100 percent thereafter.

Effective Date.—January 1, 1998.

Sec. 11. Small Employer Credit

Present Law.—No provision.

Explanation of Provision.—Certain small employers (those with 50 or fewer employees during the year) that employ low-wage workers would be eligible for a tax credit to reduce their liability for health premiums. An employer would not be eligible for the credit if its average full-time equivalent salary per employee exceeds \$26,000. An employer's deduction for providing health insurance would be reduced by the amount of the credit. Employers could claim the credit during the year on an estimated basis by reducing the amount of employment taxes that would otherwise be owed.

The credit percentage would be dependent upon the number of individuals employed by the employer. Employers of 1 to 25 employees would be entitled to a maximum credit of 50 percent in 1998 through 2002, 30 percent in 2003, and 15 percent in 2004. Employers of 26 to 50 employees would be entitled to a maximum credit of 37.5 percent in 1998 through 2002, 20 percent in 2003, and 10 percent in 2004. The small employer credit would not be available after 2004.

The maximum credit would be determined by multiplying the credit percentage by the employer's total required Medicare Part C premium liability for the year, including the employer's liability for non-enrolling employer payments, and reduced by the amount of any family premium credit. For small employers who provide coverage through a qualified health plan other than Medicare Part C, the credit would be computed based upon the amount of employer Part C payments that would have been required had the employees been enrolled in Medicare Part C. The credit would be ratably phased out if the full-time equivalent average salary per employee exceeds \$12,000, but is less than \$26,000.

An employer's average full-time equivalent salary per employee would be calculated by dividing the employer's payroll for the year by the number of full-time equivalent employees. In the case of partners and sole proprietors, the employer's payroll includes net earnings from self employment (within the meaning of section 1402(a) of the Internal Revenue Code). The credit would not be available with respect to premiums paid on behalf of a sole proprietor, a partner who owns more than 10 percent of a partnership, an owner of more than 10 percent of a corporation, or a member of the family of such a proprietor, partner, or owner.

Effective Date.—January 1, 1998.

Sec. 12. Large and Small Employers

Present Law.—No provision.

Explanation of Provision.—If an employer had more than 100 employees on at least 20 days (each day being in a different week) in the preceding calendar year, the employer would be a large employer. For this purpose, both full-time and part-time employees would be considered, i.e., any employee employed for any portion of the day is counted as one employee. The number of employees of an employer would be determined on a controlled group basis, using the present-law aggregation rules of Code sections 52(a), 52(b), and 414(m). Any employer which is not a large employer would be a small employer.

For purposes of determining eligibility for the small employer credit, an employer must consider the number of employees employed during the current calendar year rather than the preceding calendar year. An employer would be ineligible for the small employer credit if it employs more than 50 employees on at least 20 days (each day being in a different week) during the current calendar year.

Effective Date.—The provision would be effective as of January 1, 1996.

Sec. 13. Employer Obligations to Cover Employees Under Qualified Health Plans

Present Law.—(a) Categories of qualified health plans which must be offered.—No provision.

(b) Employer premium contributions.—No provision.

(c) Employees who need not be offered coverage through qualified health plans.—No provision.

(d) Employees who may decline coverage under the employers' qualified health plans.—No provision.

Explanation of Provision.—Large employers would be required to offer their employees coverage under qualified health plans. Small employers could offer their employees coverage either under a qualified health plan or by enrolling them in Medicare Part C. Certain part-time, seasonal and temporary employees need not be offered coverage under the employer's qualified health plans, but the employer would instead be required to pay Part C premiums with respect to such employees. If a large employer fails to offer coverage under the employer's qualified health plans to any employee required to be offered such coverage, the employer would be subject to an excise tax equal to 25 percent of the wages paid by such employer to such employee. The Secretary of the Treasury would be permitted to waive all or part of this tax under certain circumstances, if the Secretary determines that the payment of such tax is excessive relative to the failure involved.

(a) Categories of qualified health plans which must be offered.—Large employers would be required to offer at least two categories of qualified health plans: (1) a managed-care plan, if one is available to the employer, and (2) a plan that provides an unlimited choice of providers (as defined in Title V of the bill). Employers could also offer to eligible employees a plan consisting of both a high deductible health care insurance policy and a medical savings account. These plans would be referred to as "high deductible medical savings plans". Only qualified health plans could be offered by an employer. An employer could also meet its obligation by provid-

ing coverage under a State benefit-management program (as defined in Title IV of the bill).

An employer could not offer a high deductible medical savings plan to an employee if it is reasonably expected that the employee would be eligible for subsidies under subtitle D of title XXIII of the Social Security Act or, if the employee were a Medicare Part C individual, the employee would be eligible for a reduced premium.

Employers would be required to have an annual open enrollment period of at least 45 days, during which employees could enroll in any of the qualified health plans offered by the employer. Plans offered by the employer would be required to extend coverage to all young dependents of an employee. For any employee with young dependents, the employer would be required to make contributions based on the family premium.

(b) Employer premium contributions.—For an employee enrolled in a qualified managed care plan, the minimum employer contribution would be 80 percent of the premium for the employee's class of enrollment for the lowest-cost managed care plan offered by the employer. For an employee enrolled in a health plan allowing an unlimited choice of providers (other than a high-deductible health insurance plan) the minimum employer contribution would be 80 percent of the premium for the employee's class of enrollment for the lowest-cost plan offered by the employer which allows an unlimited choice of providers. For an employee enrolled in a State benefit management program, the minimum employer contribution would be 80 percent of the lowest premium imposed for coverage for the employee's class of enrollment.

For an employee enrolled in a high deductible medical savings plan, the minimum required employer contribution would be 80 percent of the premium for the high deductible health insurance plan (reduced proportionally for part-time employees) for the employee's class of enrollment. In addition, the employer would be required to contribute to a medical savings account for the employee the difference between (1) the employer contribution that would apply if the employee were covered under an unlimited-choice-of-provider plan that was not a high deductible plan, and (2) the employer contribution amount made for coverage under the high deductible health insurance plan. For purposes of determining the contribution that would otherwise be made for the employee (and, therefore, the amount of the contribution that must be made to the medical savings account), the premium for a self-insured plan would be determined on an actuarial basis.

Employer contributions toward qualified health plans would be paid directly to the insurer (or sponsor in the case of a self-insured plan).

(c) Employees who need not be offered coverage through qualified health plans.—An employer that offers its employees coverage under qualified health plans would be required to extend the offer to all employees employed as of the first day of any calendar month, except in the following circumstances. Employers would not be required to offer qualified health plan coverage to any employee who: (1) normally works less than 25 hours per week; or (2) is expected to work for the employer for less than a 120-day period. In addition, with respect to employees who work at least 25 hours but

less than 35 hours per week, employers would not be required to offer such employees enrollment under a qualified health plan offered by the employer until the employee has been employed at least 25 hours per week by that employer for a 3-month period.

In the case of a plan maintained pursuant to a collective bargaining agreement, an employer would not be required to offer enrollment in the plan to any additional employees beyond those required to be covered by the plan under the collective bargaining agreement.

For any employee who is not offered coverage under the employer's qualified health plans for one of these reasons, the employer would instead be required to make either (1) a contribution to Medicare Part C (if the employee is enrolled in Medicare Part C), or (2) a non-enrolling employer payment (if the employee is enrolled in another qualified health plan).

Employers would not be required to offer coverage to any exempt employee, nor would they owe any Medicare Part C premiums or non-enrolling employer payments with respect to such employees.

(d) Employees who may decline coverage under the employers' qualified health plans.—Certain employees would be permitted to decline coverage under the qualified health plans provided by the employer. If an employee provides evidence of enrollment in another qualified health plan (such as a plan offered by a spouse's employer), the employee could decline coverage under the qualified health plans offered by the employer, but the employer would be required to make a non-enrolling employer payment with respect to that employee. An employee who is eligible for a low-income subsidy and who is employed by a small employer could elect to obtain coverage through Medicare Part C rather than under a qualified health plan, and the employer would be required to contribute toward the employee's Part C premium. An employee who normally works at least 25 hours, but less than 35 hours, per week could decline coverage under the qualified health plans offered by the employer, and instead enroll in another qualified health plan or in Medicare Part C. For such employees, the employer would be required to make either (1) a contribution to Medicare Part C (if the employee is enrolled in Medicare Part C), or (2) a non-enrolling employer payment (if the employee is enrolled in another qualified health plan).

Until January 1, 1998, any employee would be permitted to decline coverage under the qualified health plans offered by an employer, and the employer would have no contribution obligations with respect to such employee.

Effective Date.—The provisions would be effective for large employers as of January 1, 1996, and for small employers as of January 1, 1998.

Sec. 14. Other Employer Obligations

Present Law.—(a) General maintenance of effort requirements.—No provision.

(b) Maintenance of effort with respect to early retirees.—No provision.

(c) Nondiscrimination rules.—No provision.

(d) Continuation coverage modifications.—No provision.

(e) Reporting requirements.—Employers are required to file with the IRS and SSA annual information reports (Forms W-2) on wages paid to each employee, income tax and FICA tax withholding from each employee, and related information. Employers must provide employees with copies of these information reports.

Explanation of Provision.—Employers would be required to meet certain other requirements, effective as of the date of enactment of the bill. Any employer failing to meet such requirements with respect to any employee would be subject to an excise tax of \$100 per day with respect to each failure and each employee.

(a) General maintenance of effort requirements.—Any employer who, as of January 1, 1994, was offering health benefits to its employees would be required to maintain that level of benefits offered for all employees (and spouses and dependents covered under their health plan) through January 1, 1999. To the extent such benefits are provided pursuant to a collectively bargained agreement, employers would be required to continue to offer the benefits pursuant to the agreement, or for the five-year period, whichever period is longer.

(b) Maintenance of effort with respect to early retirees.—Any employer who, as of October 1, 1993, was paying a portion of the health costs for retirees aged 55 through 64 (or their spouses or dependents) would be required to continue making premium payments for such retirees by paying at least 80 percent of the applicable health premium for the employee's class of enrollment for either the employer's qualified health plan or Medicare Part C. Employers would be relieved of this obligation if the retiree, spouse or dependent elects coverage under another qualified health plan, or when the retiree and dependents reach age 65. Employers with contractual retiree health obligations that exceed benefits under the guaranteed national benefit package would be required to provide such benefits in accordance with their contractual obligations. For purposes of determining early retiree health obligations, the term "employer" could include a State or local retirement system.

(c) Nondiscrimination rules.—If an employer elects to make an additional health benefit payment for any full-time employee, the employer would generally be required to offer the same additional health benefit payments to all full-time employees. However, this requirement would not apply to coverage provided pursuant to a collective bargaining agreement or to the terms of a multiemployer plan.

For employees enrolled in qualified health plans provided by the employer, the employer could meet the nondiscrimination requirement if, with respect to each employee within a particular class of enrollment: (1) the additional payment amount is equal to a fixed percentage of the premium for the qualified health plan selected by the employee; (2) the additional payment amount is equal to a fixed percentage of the premium for the lowest-cost plan offered by the employer within the category of plan selected by the employee (i.e., unlimited choice of providers, managed care, or high deductible medical savings plans); (3) the employer contribution is equal to a fixed dollar amount for all employees, such that the contribution is either the minimum level of contribution for a managed care plan,

or the minimum level of contribution for an unlimited choice of provider plan, whichever is greater.

For employees enrolled in Medicare part C, if an employer elects to contribute more than the requisite 80 percent of the applicable premium for each of its employees, the same percentage must be paid with respect to all of its employees (reduced proportionally in the case of part-time employees). With respect to part-time employees, however, the employer could elect to contribute up to the full percentage paid for full-time employees, rather than making pro rata contributions. For example, an employer that elects to contribute 100 percent of the applicable premium for each full-time employee could also elect to pay 100 percent of the applicable premium for each part-time employee, regardless of the number of hours worked by the employee.

(d) Continuation coverage modifications.—Continuation of health insurance coverage under the COBRA rules would be extended under a transitional period until the Medicare Part C program is established. Any employee who is eligible for continuation coverage on the date of enactment could continue such coverage until the earlier of (1) January 1, 1998, or (2) the occurrence of a terminating event, as defined under present law, other than the expiration of the “maximum required period” (as defined in section 4980B(f)(2)(B)(i) of the Internal Revenue Code). Such terminating events include coverage under another employer-sponsored plan or failure to pay the required premium. After January 1, 1998, the health care continuation rules generally would continue to apply as under present law and coverage under Medicare Part C would constitute coverage under a group health plan for purposes of the health care continuation rules.

(e) Reporting requirements.—Employers would be required to include on their employees’ annual W-2 forms the total amount of mandatory employer contributions and the total amount of elective contributions made toward Part C coverage with respect to each employee. In addition, any employer making Part C contributions with respect to any employee would be required to file annual information reports with the IRS setting forth the name and tax identification number of the employee, the employee’s spouse, and any young dependents of the employee, and the class of enrollment with respect to which the payments were made. The Secretary of HHS would be required to file with the IRS similar reports and give copies of the statements to individuals with respect to any individual making direct payments for Part C premiums.

Employers would also be required to report to each employee on a monthly basis the mandatory and elective amounts paid toward the employee’s Part C coverage. The monthly information generally would be provided on the employee’s statement of wages for the period which includes the last day of the calendar month.

The administrator of any qualified health plan (and, with respect to individuals enrolled in Medicare Part A, the Secretary of HHS) would be required to report, with respect to each primary insured individual covered by the plan, the following information: the name of the plan, the address of the plan administrator, the names and tax identification numbers of all individuals (including spouses and young dependents) insured under the plan, and the months of cov-

erage. Such information would also be required to be included on an annual information report filed with the IRS.

Effective Date.—Provisions (a), (b) and (d) would be effective upon the date of enactment. Provisions (c) and (e) would be effective with respect to employees enrolled in qualified health plans provided by a large employer as of January 1, 1996 with respect to employees enrolled in qualified health plans provided by the employer, and with respect to all other employees as of January 1, 1998.

Sec. 15. Exempt Employees

Present Law.—No provision.

Explanation of Provision.—No employer contribution would be required with respect to any employee who certifies to the employer that he or she is exempt from Medicare Part C liability for one of the following reasons: (1) the employee is a young dependent; (2) the employee is a United States citizen living abroad; (3) the employee is a nonresident alien; (4) the employee is an individual receiving Medicare Part A or active duty military benefits; (5) the employee has been granted an exemption based on his or her religious faith; or (6) the employee is a prisoner. The requirements for each of these exemptions are described in detail in Subtitle A of this title, “Individual Responsibilities”.

No employer premium payment would be required with respect to services performed at a “sheltered workshop” within the meaning of Code section 151(c)(5)(B).

No non-enrolling employer contributions would be required with respect to an exempt employee.

Effective Date.—The provision would be effective for large employers as of January 1, 1996, and for small employers as of January 1, 1998.

Sec. 16. Employers in U.S. Possessions

Present Law.—No provision.

Explanation of Provision.—Employers in Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands would be subject to all of the provisions described above, regardless of whether the possession enters into an agreement with the United States to impose a tax on its residents to collect the individual share of Medicare Part C premiums and pay over the premiums to the U.S. Treasury. (Such agreements are described in more detail in the “Individual Responsibilities” section, above.) Notwithstanding any other provision of law, no amount collected under these provisions would be covered over to any possession of the United States.

Effective Date.—The provision would be effective for large employers as of January 1, 1996, and for small employers as of January 1, 1998.

Sec. 17. Disclosure of Taxpayer Information

Present Law.—The Internal Revenue Code prohibits disclosure of tax returns and return information, except to the extent specifically authorized by the Code (sec. 6103). Unauthorized disclosure is a

felony punishable by a fine not exceeding \$5,000 or imprisonment of not more than five years, or both (sec. 7213). An action for civil damages also may be brought forth for unauthorized disclosure (sec. 7431). No tax information may be furnished by the Internal Revenue Service (IRS) to another agency unless the other agency has established procedures satisfactory to the IRS for safeguarding the tax information it receives (sec. 6103(p)).

Explanation of Provision.—The bill would permit disclosure of certain taxpayer return information to HHS for use in determining or verifying eligibility for health premium certificates. Disclosable information would be limited to taxpayer return information relating to adjusted gross income, tax-exempt interest income, marital status and the number of personal exemptions.

Under the bill, taxpayer return information could be disclosed only in response to a written request from the Secretary of HHS and only with respect to a taxpayer's application for a health premium certificate. Moreover, disclosure could be made only to HHS employees and could be used by them only to the extent necessary to determine or verify a taxpayer's eligibility for a health premium certificate.

The bill would require HHS and its employees to comply with the safeguards presently contained in the Code governing the use of disclosed tax information. Also, the bill would apply the present-law penalties for unauthorized disclosure of information to HHS and its employees.

Effective Date.—The provision would be effective January 1, 1998.

Title III. Benefits

Subtitle A. Guaranteed national benefit package

Sec. 1. General Description

Present Law.—There are no Federal requirements that specify the benefits of private health plans. In general, health insurance policies are not subject to uniform benefit requirements; however, many States require health insurance policies sold or issued in the State to include various mandated benefits.

The Employee Retirement Income Security Act (ERISA) pre-empts States from regulating employee welfare benefit plans, including employee health plans, and establishes specific requirements for private sector employers and their plans. However, ERISA does not regulate the benefit content of plans.

Federal law establishes uniform benefits to be covered under the Medicare program. Medicare Part A provides coverage for inpatient hospital services, post-hospital skilled nursing facility (SNF) care, home health services and hospice care. Patients must pay a deductible (\$696 in 1994) each time their hospital admission begins a benefit period (defined as beginning when a patient enters a hospital and ending when he or she has not been in a hospital or SNF for 60 days). Medicare pays the remaining costs for the first 60 days of care. The limited number of beneficiaries requiring care beyond 60 days are subject to additional copayments (\$174 per day for days 61–90 and \$348 per day for days 91–150). Patients requiring

SNF care are subject to a daily coinsurance charge for days 21–100 (\$87 in 1994). There are no cost-sharing requirements for home health care, and limited charges for hospice care.

Medicare Part B provides coverage for physician services, laboratory services, durable medical equipment, outpatient hospital services, outpatient rehabilitation services and other medical services. It also covers defined preventive services such as screening mammography, pap smears, pneumococcal vaccines, and hepatitis B vaccines for certain high-risk individuals. The program generally pays 80 percent of Medicare's fee schedule or other approved amount after the beneficiary has met the annual \$100 deductible. The beneficiary is liable for the remaining 20 percent. Medicare covers outpatient rehabilitation services, including comprehensive outpatient rehabilitation facility services, physical therapy, occupational therapy and speech pathology services, when such services are reasonable and necessary to treat an illness or injury, without an explicit exclusion in statute for treatment for congenital conditions.

Medicare coverage of chiropractic services is limited to treatment by means of manual manipulation of the spine to correct a subluxation of the spine demonstrated to exist by x-ray; however, Medicare does not cover x-rays performed by chiropractors necessary to demonstrate the existence of the subluxation of the spine.

Federal law establishes standards for private Medicare supplemental insurance policies, known as Medigap policies. Medigap policies are required to be certified as meeting Federal standards with respect to standardization of benefits, loss ratios, non-duplication of benefits, non-discrimination in enrollment, and marketing.

Explanation of Provision.—The guaranteed national benefit package would be defined in statute. In general, the guaranteed national benefit package would conform with the benefits currently provided under Medicare Parts A and B, with additional benefits as specified below. The guaranteed national benefit package would be covered under Medicare Part C, and would also be required to be offered by all qualified health plans, including self-insured plans.

Individuals and employers would be able to purchase supplemental Medigap-type policies for coverage of additional benefits and cost-sharing (see requirements for supplemental policies described in Title V). Employers that elect to self-insure could provide supplemental benefits, in addition to the required national benefit package.

The guaranteed national benefit package would include the following additional benefits: (i) a single deductible of \$500 per individual and \$750 per family (in 1994 dollars, indexed between 1994 and 1998 to the nominal growth in per capita gross domestic product, indexed in subsequent years to the rate of growth in Medicare Part C spending, as specified in Title VIII of this Act); (ii) coverage of outpatient prescription drugs with a separate \$500 deductible, a 20 percent co-insurance and a separate \$1,000 out-of-pocket limit for prescription drugs; and (iii) inpatient hospital services and up to 100 days of post-hospital SNF care, without co-insurance, without a separate hospital deductible, and without spell-of-illness restrictions.

In addition, as of January 1, 2003, the guaranteed national benefit package would include a cap on out-of-pocket expenditures of \$5,500 per individual and \$11,000 per family (in 1994 dollars). The cap would be indexed between 1994 and 1998 to the nominal growth in per capita gross domestic product, and indexed in subsequent years to the rate of growth in per capita Medicare spending, as specified in Title VIII of this Act. The cap would apply to all cost-sharing for covered items services other than outpatient prescription drugs.

A high deductible plan, as defined in title V, would provide the standard cost-sharing schedule, except that the deductible would be an amount established by the carrier offering the plan. For individual policies, the deductible could not be less than \$1,500 or more than \$2,500. For single parent and family policies, the deductible could not be less than \$2,150 or more than \$3,750. A high deductible plan could only be offered in conjunction with a medical savings account (described in title XI).

An alternative cost-sharing schedule would be established for managed-care plans. The schedule would provide for the following copayments (in 1994 dollars and indexed as the deductible amounts above, rounded to the nearest whole dollar): \$15 for physician visits and other health professional visits; \$30 for emergency room services for non-emergency treatment; \$15 for hospital outpatient and other ambulatory medical and surgical services; for outpatient prescription drugs, the lesser of \$10 or 20 percent for a generic product, the lesser of \$10 or 20 percent for a drug that is not a generic product if an equivalent generic product is not available, or the greater of \$10 or 20 percent for a drug that is not a generic product if a generic product is available; \$15 for family planning services except prenatal visits; \$30 for intensive community mental illness and substance abuse services; \$15 for brief outpatient mental illnesses and substance abuse visits except psychotherapy; \$25 for outpatient psychotherapy visits. The cap on out-of-pocket expenditures would also apply to managed care plans.

Items and services covered under the guaranteed national benefit package provided under a managed care plan, other than through the plan's provider network, would be subject to a cost-sharing schedule established by the Secretary, in consultation with the National Association of Insurance Commissioners.

The guaranteed national benefit package would include expanded mental health and substance abuse benefits as defined in Section 3 of Subtitle B, and outpatient prescription drugs, as defined under Section 4 of Subtitle B.

Specific additional services would be covered for children to age 19. Newborn, well-baby and well-child services for children would be covered and would not be subject to deductibles or other cost-sharing requirements. Newborn and well-baby care would be consistent with the services and periodicity schedule specified by the Secretary, in consultation with the American Academy of Pediatrics. The guaranteed national benefit package would also cover attendance by pediatricians at high-risk deliveries.

Well-child services, including routine office visits, routine immunizations, routine lab tests, and dental care (preventive dental exams, fillings and oral surgery) would be specified by the Sec-

retary, in consultation with the American Academy of Pediatrics and the Academy of Pediatric Dentistry. Well-child services would be defined to include periodic lead screening which would be based upon recommendations developed by the Centers for Disease Control and Prevention (CDC), and child abuse assessment.

Coverage of outpatient rehabilitation services for children would be clarified to include treatment of congenital conditions, provided other current law requirements are met. In addition, hearing aids for children would be covered.

Specified immunizations (booster immunizations against tetanus and diphtheria) would be covered for immunizations provided every ten years for individuals between the ages of 19 and 64. The Secretary, in consultation with appropriate experts, including the CDC's Advisory Council on Immunological Practices, would have the authority to add to, or modify, the coverage of vaccinations and other clinical preventive benefits established under the guaranteed national benefit package, provided such services were determined to be clinically appropriate and cost-effective and the Secretary determined that the modifications would not have a significant impact on Medicare Part C premiums.

All pregnancy-related services would be covered. Pre-natal services would be covered without cost-sharing requirements. Family planning would be covered, including voluntary planning services and contraceptive drugs and devices.

Additional preventive benefits would be covered under the guaranteed national benefit package, including immunizations and colorectal screening. Screening mammography would be covered, based upon a modified schedule: one exam for women ages 35-39; once per 23-month period for women ages 40-49 following the month in which a screening mammography was performed (once per 11-month period for high-risk women in this age group); and once per 11-month period for women ages 50 and older following the month in which a screening mammography was performed, rather than once per 23-month period for women ages 50 and older which is currently specified under Medicare Part B.

The current law schedule for coverage of screening pap smears and pelvic exams would be modified under the guaranteed national benefit package. Screening pap smears, pelvic exams and clinical breast exams would be covered on an annual basis for women who have reached childbearing age, until negative results appear for three consecutive years, with one screening pap smear and one pelvic exam per three-year period thereafter. Women at high risk for cervical cancer would be covered on an annual basis.

Screening for women at risk for sexually-transmitted diseases including tests for chlamydia and gonorrhea would be covered annually for women between the ages of 13 and 49.

Colorectal screening would be added as a benefit to Medicare and would be covered under the guaranteed national benefit package for individuals at high risk for colorectal cancer, with coverage of fecal occult blood tests (FOBT) screening on an annual basis, sigmoidoscopies for the early detection of colorectal cancer once per five year period, and screening colonoscopies for individuals at high risk for colorectal cancer once every four years.

Individuals at high risk for colorectal cancer would be defined by the Secretary. In establishing criteria for determining whether an individual is at high risk for colorectal cancer, the Secretary would take into consideration: family history, prior experience of cancer, a history of a chronic digestive disease condition, and the presence of any appropriate, recognized, gene markers for colorectal cancer. Tests for such markers would be covered based on current policy.

The Office of Technology Assessment would continue to examine the efficacy of preventive services and the appropriate schedule of preventive services for high-risk populations. The Office of Technology Assessment would make recommendations for modifications to the benefit package to the Congress. The Secretary would be permitted to modify the frequency criteria for preventive services.

Coverage of chiropractic services would be modified to include the x-ray services necessary to demonstrate the existence of the subluxation of the spine.

Items and services provided to individuals receiving treatment as part of a qualifying investigational treatment would be covered, provided such items and services would otherwise be covered under the guaranteed national benefit package. For purposes of this provision, a qualifying investigational treatment would mean a treatment for which the effectiveness had not yet been determined and which is under clinical investigation as part of an approved research trial.

An approved research trial would be defined to include a research trial approved by the Secretary or a qualified non-governmental research entity as defined in guidelines of the National Institutes of Health, including guidelines for the National Cancer Institute-designated cancer support grants, or a peer-reviewed and approved research program, as defined by the Secretary, conducted for the primary purpose of determining whether or not a treatment is safe, efficacious, or having any other characteristic of a treatment which must be demonstrated in order for the treatment to be medically necessary or appropriate.

The guaranteed national benefit package would not cover items and services normally paid by other funding sources (as defined by the Secretary), such as the cost of the investigational agent or device itself, the costs of any non-health services that might be required for a person to receive the treatment, and the costs of managing the research. A drug, biological, or medical device not otherwise covered under the guaranteed national benefit package would be considered to be investigational. Nothing would prohibit a private qualifying health plan from covering such drugs, biological and medical devices, including treatments of investigational new drugs (IND).

Medicare's definitions of providers would apply to the guaranteed national benefit package for benefits covered under Medicare Parts A, B, and C. For health plans other than Medicare Parts A, B, and C, State laws providing for reimbursement to a class of providers would not be preempted, provided the individual or entity is in a class of provider legally authorized under State law to provide the item or service.

In the definition of covered services under the guaranteed national benefit package, the Committee has no intention of limiting,

in any way, the scope of practice as defined in State medical practice acts and other similar State laws.

Effective Date.—Effective as of January 1, 1996 for employers with more than 100 employees that elect to self-insure. Otherwise, the provisions of this section would be effective for all health insurance plans sold to employers and individuals as of the date upon which the Federal insurance reform standards take effect in a given State, but not later than January 1, 1998.

Sec. 2. Mental Health and Substance Abuse Services Covered Under the Guaranteed National Benefit Package

Present Law.—Mental health and substance abuse services are provided, with defined limitations and copayments, under the Medicare program. Medicare payment for inpatient psychiatric hospital services provided by a psychiatric hospital is limited to 190 days during a patient's lifetime. Inpatient substance abuse services, and services consistent with alcohol detoxification or treatment for drug or chemical withdrawal, are also covered. Partial hospitalization services are covered under Medicare to individuals who would otherwise require inpatient psychiatric care.

Medicare Part B pays 50 percent of the recognized payment amount for outpatient psychotherapy services, which can include treatment for problems associated with drugs or alcohol, for an individual who is not an inpatient of a hospital.

In addition, Medicaid covers a variety of mental health and substance abuse services to eligible low-income individuals. Included among the mandatory services covered under Medicaid are early and periodic screening, diagnostic and treatment services (EPSDT), which include screening services to determine the existence of certain mental illnesses or conditions and any services which are covered under Medicaid that may be necessary to treat or ameliorate a defect, physical or mental illness, or another condition identified by the screen.

There are a number of additional Federal programs which may be used under current law to fund social services and educational programs for qualified children and families. Such services are used, at least in part, to fund residential, community and home-based services for seriously disturbed children.

Title IV of the Social Security Act provides grants to States for aid and services to needy families with children and for child welfare services. The resources provided under Title IVA, Aid to Families with Dependent Children, are used in part, to help maintain children in their homes, including children who are seriously disturbed. Title IVE, Federal Payments for Foster Care and Adoption Services, are used in part to support seriously and emotionally disturbed children in therapeutic foster care settings.

In addition, under the Education of the Handicapped Act, seriously disturbed children between the ages of three and twenty-one are provided appropriate education as well as related mental health services that are needed to ensure appropriate learning. Also under this Act, States are mandated to provide special education services to qualified children from birth to age five.

Thirty-two States currently require health insurance policies sold to individuals and employers to cover mental health and substance abuse benefits.

(a) Intensive residential services.—No provision.

(b) Intensive community services.—No provision.

(c) Outpatient psychotherapy visits for children and adolescents.—No provision.

(d) Special requirements for services provided to children and adolescents through organized systems of care.—No provision.

(e) Comprehensive managed mental health and substance abuse programs.—No provision.

(f) Advisory commission on mental health and substance abuse services.—No provision.

Explanation of Provision.—(a) Intensive residential services.—Coverage under the guaranteed national benefit package would be provided in the following residential programs: (i) residential detoxification centers; (ii) crisis residential programs or mental illness residential treatment programs; (iii) therapeutic family or group treatment homes; (iv) residential centers for substance abuse treatment.

These services would be covered for up to 120 days per year; however, residential services could be substituted for inpatient services as long as the residential services did exceed the estimated costs which would be incurred in an inpatient setting for an individual to complete treatment. The Secretary would be directed to develop standards for the appropriate management of all intensive residential services.

(b) Intensive community services.—The following intensive community services would be covered for a maximum of 90 days per year and with a 20 percent copayment: (i) psychiatric rehabilitation services; (ii) behavioral aide services; (iii) in-home services; and (iv) ambulatory detoxification. Day treatment services for children would be available for 180 days per year with a 20 percent copayment, with no trade-off for inpatient hospital days. Case management would be available without limits or copayments for seriously emotionally disturbed children and adults with serious mental illness and adults and children with serious substance abuse disorders. The Secretary would be directed to develop standards for the appropriate management of these services.

The term “intensive community-based services,” either facility-based or free-standing, would include partial hospitalization. These services would be provided as an alternative to hospitalization as well as to prevent relapse which can lead to hospitalization. These services would be provided through programs meeting applicable State certification or private accrediting standards. Services would be provided under the supervision of a physician or non-physician mental health professional licensed by the State, provided that such supervision is not prohibited by the scope of practice of the non-physician mental health professional. Services would be provided pursuant to an individualized, written plan of treatment established and periodically reviewed by a physician in consultation with a treatment team consisting of appropriate staff participating in such a program.

Assessment, diagnosis and entering patients into intensive community based services can be conducted independently by licensed mental health professionals to the extent permitted by State law. It is the intent of the committee to recognize the interdisciplinary and collaborative aspects of treatment provided in these settings.

(c) Outpatient psychotherapy visits.—Unlimited outpatient psychotherapy visits for children would be provided through age 18 with a 20 percent copayment. The initial five outpatient psychotherapy sessions for adults would be available with a 20 percent copayment.

(d) Special requirements for services provided to children and adolescents through organized systems of care.—(i) In conjunction with States, health plans would ensure that the mental illness and substance abuse services described in this section and provided to an eligible person are furnished through organized systems of care where available, if the eligible person is a person under 19 years of age who has a serious emotional disorder or substance abuse disorder and is currently involved or at imminent risk of being involved with one or more public child-serving agencies, including child welfare, special education, and juvenile or criminal justice. For purposes of this provision, the term “organized system of care” means a community-based service delivery network, which may consist of public or private providers that meet the following requirements:

(i) The system has established linkages with existing mental illness and substance abuse service delivery programs in the plan service area (or is in the process of developing or operating a system with appropriate public agencies in the area to coordinate the delivery of such services to individuals in the area);

(ii) The system provides for the participation and coordination of multiple agencies and providers that serve the needs of children in the area, including agencies and providers involved with child welfare, education, juvenile or criminal justice, health care, mental health, and substance abuse treatment;

(iii) The system provides for the involvement of the families of children to whom mental illness and substance abuse services are provided in the planning of treatment and the delivery of services;

(iv) The system provides for the development and implementation of individualized treatment plans by multidisciplinary and multi-agency agency teams that are recognized and followed by the requisite providers in the area;

(v) The system ensures the delivery and coordination of the range of mental illness and substance abuse services required for individuals under 19 years of age who have a serious emotional disorder or a substance abuse disorder;

(vi) The system provides for the management of the individualized treatment plans and for a flexible response to treatment changes over time.

(e) Comprehensive managed mental health and substance abuse Programs.—Broad flexibility would be available to States to establish, at the State’s option, comprehensive managed mental health and substance abuse programs. The programs would promote the development of integrated delivery systems for the management of mental health and substance abuse services for low-income adults

and children with serious mental illness or emotional disturbance. The programs would allow individuals to continue to receive the services defined in the national guaranteed benefit package for mental health and substance abuse, but without the limits and, at the State's option, with reduced copayments.

Eligibility of individuals to participate in comprehensive managed mental health and substance abuse programs would be based on Federal standards, although States would have the ability to define eligibility in greater specificity.

The Federal standards would assure that State programs targeted services to adults with serious mental illness or substance abuse problems and to children with serious emotional disturbance and substance abuse problems, as evidenced by a need for multiple services (either based on past history, or based on a prediction of future need), and only to such children and adults who have a disorder which is expected to last at least one year.

State programs will develop, in conjunction with the Secretary, uniform patient placement criteria.

States would be required to submit a plan for a comprehensive managed mental health or substance abuse program. The plan would be required to specify:

(i) the management, access and referral structure which the State would use to promote and achieve integration of the basic benefits and other appropriate services which the State intends to integrate under the State's comprehensive managed mental health and substance abuse programs;

(ii) the proposed linkages with agencies and providers that serve the needs of adults with serious mental illness or substance abuse, or children with serious emotional disturbance or substance abuse (including agencies and providers involved with child welfare, education, juvenile justice, corrections, vocational rehabilitation, crime prevention, health care, mental health, and substance abuse prevention and treatment);

(iii) the detailed specifications for the program which would assure that eligible individuals have access to each service, as appropriate, in the basic benefit (including current Medicare benefits and the enhanced benefits added by this proposal);

(iv) the definition of "serious mental illness for adults," "severe emotional disturbance in children," "substance abuse in adults" and "substance abuse in children," within the State's program, based on Federal standards;

(v) a description of how the families of adults and children to whom mental illness and substance abuse services are proceeded would be included in the planning of treatment, the delivery of services, and the evaluation of interventions;

(vi) the proposed system for the development and implementation of individualized treatment plans through multi-disciplinary or multi-agency teams;

(vii) the description of how the State will provide for public participation in the development and ongoing assessment of the program;

(viii) the description of the grievance procedure that would be available to eligible individuals dissatisfied with the program;

(ix) the method and components of program review which would include assessments of clinical outcomes, residential stability, vocational and academic achievement, and management of costs; and

(x) the additional Federal, State, and local funds that the State proposes to integrate in order to finance the program (e.g., Title IV, Sections E and A, and Public Education sources).

Any individual who elects to enroll in a State managed mental health or substance abuse benefit program would be deemed to have waived the right to mental health and substance abuse benefits provided under the guaranteed national benefit package. With respect to such individuals enrolled in Medicare Parts A and B or C, the Secretary would make payments to the State on a capitated basis which would reflect the actuarial value of mental health and substance abuse benefits that would otherwise be provided under the respective programs. With respect to such individuals enrolled in a private plan, the sponsor of a private health plan, including insured and self-insured health plans, would make a monthly per capita payment to a State managed mental health and substance abuse benefit program. The sponsor would not be obligated to make any other payment for mental health and substance abuse services for such an individual for those months in which the individual was enrolled in a State program.

The per capita payment made by the sponsor of a private health plan to the State would be an amount determined in accordance with a methodology established by the Secretary that reflects the portion of the premium associated with the coverage of mental health services under the guaranteed national benefit package that would be provided to the individual under the plan if the individual were not enrolled in the State program.

A State operating a program could elect to permit private health plans to enroll in the program individuals who otherwise would be eligible for enrollment in the program except that they do not meet income requirements. The State would impose on the health plan an appropriate premium with respect to such enrollment.

(f) Advisory commission on mental health and substance abuse services.—The Director of the Office of Technology Assessment (OTA) would appoint an Advisory Commission on Mental Health and Substance Abuse Services within one year of enactment. The membership of the Commission would include, but need not be limited to, physicians, mental health professionals, individuals with knowledge of and experience in the delivery of mental health and substance abuse services, and representatives of consumers.

The Commission would examine: (i) the variety of mental health and substance abuse services provided in the United States, together with the types of providers furnishing such services and the methods under which the providers receive payment for furnishing such services; (ii) the means available to manage appropriately the delivery of mental health and substance abuse services and coordinate the delivery of such services with the delivery of other health services, and to achieve parity in the scope of mental health and substance abuse services; (iii) the variations in the utilization of and costs associated with mental health and substance abuse services among different geographic regions and demographic groups; (iv) the incidence and prevalence of severe mental illness and sub-

stance abuse among incarcerated adults and juveniles and the relationship between the mental health and substance abuse treatment provided to these individuals and the length of time these individuals are incarcerated; (v) the standards for training and certifying providers of mental health and substance abuse services; (vi) the standards used to measure the quality of mental health services and to review the utilization of such services; and (vii) such other issues relating to mental health and substance abuse services in the United States as the Commission considers appropriate.

No later than January 1, 1998, and not later than January 1 of each of the four years thereafter, the Commission would submit a report to Congress which: (i) describes the issues examined by the Commission during the preceding year; (ii) evaluates the effectiveness of the guaranteed national benefit package in assuring coverage for mental health and substance abuse services and the progress that has been made in achieving parity between these services and other health services; (iii) evaluates State comprehensive managed mental health programs operated during the preceding year; (iv) analyzes trends in the delivery of mental health and substance abuse services and the costs associated with the delivery of such services; and (v) analyzes whether any distinctions in limitations on coverage and determinations of payment amounts between mental health and substance abuse services and other services in the guaranteed national benefit package should be maintained, modified, or eliminated.

The report shall include a survey of past studies, reports, and estimates on the actuarial costs of coverage for mental health and substance abuse disorders, which shall discuss the strengths and weaknesses of the various estimating methods used. The report shall include recommendations for methodologies to be used in future estimates of the costs of providing comprehensive mental health and substance abuse coverage.

The authority for the Commission would end January 1, 2002.

Effective Date.—Effective January 1, 1996 for employers with more than 100 employees that elect to self-insure. Otherwise, all provisions of this section would be effective for all health insurance plans sold to employers and individuals as of the date upon which the Federal insurance reform standards take effect in a given State, but not later than January 1, 1998.

Sec. 3. Provision of Items and Services Contrary to Religious or Moral Conviction

Present Law.—No provision.

Explanation of Provision.—A health professional or a health facility would not be required to provide an item or service in the guaranteed national benefit package, if the professional or facility objects to doing so on the basis of a religious belief or moral conviction.

Effective Date.—Effective January 1, 1996 for employers with more than 100 employees that elect to self-insure. Otherwise, the provisions of this section would be effective for all health insurance plans sold to employers and individuals as of the date upon which the Federal insurance reform standards take effect in a given State, but not later than January 1, 1998.

Sec. 4. National Health Advisory Commission

Present Law.—There is no National Health Advisory Commission under current law. There are, however, agencies established to advise the Congress, including but not limited to the Prospective Payment Assessment Commission (PPRC), the Physician Payment Review Commission (PhysPRC), and the Congressional Office of Technology Assessment.

ProPAC was established under Public Law 98-21 to advise the Congress and the Secretary on hospital payment policies under the Medicare prospective payment system (PPS). ProPAC is also required to study and make recommendations on Medicare's reimbursement of nonhospital institutional services, and report annually to the Congress background information on trends and issues in health care delivery and financing, including the impact of the prospective payment system on providers and beneficiaries. ProPAC is comprised of 17 independent experts who are appointed by the Director of OTA.

PPRC was established by the Congress under Public Law 99-272 to advise and make recommendations to the Congress on methods to reform payment to physicians under the Medicare program. The Commission is required to consider a wide range of issues including major issues in implementation of the Medicare Fee Schedule, modification of the Volume Performance Standard system, payment incentives to increase access to primary care and other services in inner city and rural areas, the supply and specialty of physicians and financing of graduate medical education, utilization review and quality control, and other related topics.

Explanation of Provision.—The National Health Advisory Commission (NHAC) would be established to monitor the impact of the Health Security Act on individuals, employers, and on government and report at least annually on their findings. The NHAC would be required to make recommendations to the Congress on a variety of topics, including but not limited to possible changes in benefits.

The Director of the Congressional Office of Technology Assessment (OTA) to appoint a commission comprised of the Chairman and Vice Chairman of ProPAC, PPRC, DrugPAC, and the Mental Health Advisory Commission (MHAC), and three additional independent members with expertise in health economics, health insurance, benefits and provider reimbursement. One member of the Commission would be appointed to as Chair.

ProPAC, PPRC, DrugPAC and MHAC would be required to analyze relevant data in their respective areas, and report to NHAC, as needed. NHAC would be authorized to hire staff of up to ten FTE's to conduct analysis on general trends and to prepare reports, but would rely upon the staffs of the other Commissions for detailed analyze. NHAC would also be authorized to commission special studies on benefit changes through the Office of Technology Assessment, or by other independent experts.

Effective Date.—Effective upon the date of enactment.

Sec. 5. Miscellaneous Provision

Present Law.—(a) Study of emergency dental services.—No provision.

Explanation of Provision.—(a) Study of emergency dental services.—The Secretary of HHS would be directed to study and report to Congress, by no later than January 1, 1996, on whether emergency services should be covered under the guaranteed national benefit package, and make recommendations, if appropriate with respect to coverage and costs.

Effective Date.—Effective upon the date of enactment.

Subtitle B. Coverage of outpatient prescription drugs and other changes in medicare benefits

Sec. 6. Coverage of Outpatient Prescription Drugs

Present Law.—(a) Definition of Outpatient Prescription Drugs.—Medicare generally does not cover outpatient prescription drugs which can be self-administered by a patient. The program currently covers certain oral cancer drugs, osteoporosis drugs, immunosuppressive drugs which are furnished to beneficiaries within one year of an organ transplant although the Omnibus Budget Reconciliation Act of 1993 expanded coverage gradually to three years by 1997, and self-administered erythropoietin for home renal dialysis patients.

Medicare also covers drugs which are provided incident to a physician service or as part of a provider service, antigens, and blood clotting factors (for hemophilia patients competent to use such factors) up to a twelve-week supply, pneumococcal vaccine, influenza vaccine and hepatitis B vaccine (for individuals at intermediate and high risk of contracting Hepatitis B).

Coverage of prescription drugs is an optional Medicaid benefit that is currently provided by all States and the District of Columbia. Within Federal guidelines, the States control the amount, duration and scope of the prescription drug benefit under Medicaid.

Prescription drugs are defined in regulation as those compound substances or mixtures prescribed for the cure, mitigation or prevention of a disease or for health maintenance that are: (i) prescribed by a physician or other licensed practitioner; and (ii) dispensed by licensed pharmacists or licensed authorized practitioners on a written prescription that is recorded and maintained in the pharmacist's records.

Under Medicaid, States do not have to pay for drugs such as amphetamines prescribed solely for weight loss, drugs used solely for infertility, vitamins for adults, barbiturates, benzodiazepines or drugs for cold and cough preparations.

If State Medicaid agencies choose to offer prescription drug coverage, they are subject to requirements related to rebate agreements, drug coverage and drug use review (DUR).

(b) Medically accepted indication.—Medicare coverage of off-label uses of anti-cancer drugs for medically accepted indications was included in the Omnibus Budget Reconciliation Act of 1993. The term "medically accepted indication" includes any use that has been approved by the Food and Drug Administration and includes another use of the drug if: (i) the drug has been approved by the FDA; and (ii) the use is supported by specified compendia, unless the Secretary has determined that the use is not medically appropriate or if the use is not indicated in one or more such compendia, or (iii)

the carrier determines (with guidance from the Secretary) that such use is medically accepted based on supportive clinical evidence in peer-reviewed medical literature identified by the Secretary. For drugs other than anti-cancer drugs, off-label use may be covered based upon the discretion of the carrier.

Under Medicaid, the term medically-accepted indication includes any use that has been approved by the FDA and includes another use if the use is supported by one or more citations included or approved for inclusion in specified compendia.

Explanation of Provision.—(a) Definition of outpatient prescription drugs.—Covered outpatient drugs would be added to services covered under Medicare Part B and Part C. A covered outpatient drug would mean any of the following products used for a medically-accepted indication: (i) a drug which is dispensed only upon a prescription and is approved for safety and effectiveness under the Federal Food, Drug, and Cosmetic Act (FDA) or was commercially available before the Drug Amendments of 1962 (and similar related drugs), including “DESI” drugs; (ii) in the case of biological products, is dispensed only upon a prescription, is licensed under the Public Health Service Act, and is produced at an establishment licensed to produce such products; (iii) insulin certified by the FDA; (iv) enteral nutrients provided as a home infusion drug; and (v) medically-necessary food for persons with Phenylketonuria (PKU) and other inborn errors of metabolism.

Covered outpatient drugs would also include covered home infusion drugs that: (i) are administered intravenously, subcutaneously, or epidurally using an access device that is inserted into the body and an infusion device, or through other means determined by the Secretary; (ii) are administered in the individual’s home (including an institution used as the individual’s home, other than a hospital or skilled nursing facility during days in which an individual is receiving a covered skilled nursing facility service) or in another setting determined by the Secretary to be cost-effective; and (iii) can be administered safely and effectively in a home setting. Home infusion drugs would also include parenteral and enteral nutrients administered in the individual’s home as defined above. The existing benefit for drugs used in conjunction with durable medical equipment and for parenteral and enteral nutrients, supplies and equipment would be replaced by the home infusion drug benefit.

The existing benefit for immunosuppressives, osteoporosis drugs, erythropoietin (EPO), oral cancer drugs, antigens, blood clotting factors, and drugs provided incident to physician services would be covered under the new benefit.

The Secretary of Health and Human Services would have the discretion not to cover certain pharmaceutical products listed in Section 1927(d) of the Social Security Act (with the exception of fertility drugs, benzodiazepines and barbiturates).

(b) Medically accepted indication.—The current coverage rules applicable to off-label use of cancer drugs would apply to all drugs under the outpatient prescription drug benefit, and drugs provided on an inpatient or an “incident to” basis. The term medically-accepted indication would include any use that has been approved by the FDA and includes another use of the drug if: (i) the drug has been approved by the FDA; and (ii) such use is supported by speci-

fied compendia, unless the Secretary has determined that the use is not medically appropriate or if use is not indicated in one or more such compendia; or (iii) the carrier determines (with guidance from the Secretary) that such use is medically accepted based on supportive clinical evidence in peer-reviewed medical literature identified by the Secretary.

Effective Date.—Covered outpatient drugs would be added to services covered under Medicare Part B and Part C, January 1, 1998.

Sec. 7. Payment Rules and Related Requirements

Present Law.—(a) Drug deductible.—Medicare payments under Part B are generally made subject to the Part B deductible and co-insurance amounts.

(b) Out-of-pocket limit.—No provision.

(c) Payment amounts.—Medicare payment for drugs currently covered under the program, other than for those drugs provided as part of a provider service, is equal to the average wholesale price, except in the case of erythropoietin (EPO) provided by a dialysis facility or supplier, in which case the payment is \$10 per 1,000 units.

Medicaid payment for a prescription drug generally has two components: (i) the estimated acquisition cost (EAC); and (ii) the dispensing fee. The EAC approximates the pharmacy's ingredient costs. The dispensing fee covers the pharmacy's additional costs to fill a prescription including administration and overhead costs. Dispensing fees range from under \$3.00 to over \$5.00 per prescription.

(d) Payment limits.—Payments for services covered under Medicare are generally subject to certain limits on the maximum amounts Medicare will recognize for payment purposes.

Under Medicaid, if three pharmaceutically and therapeutically equivalent multiple-source drugs are available, the Federal Upper Limits (FUL) program determines the corresponding payment limit. The Secretary sets the FUL payment for the drug at 150 percent of the published price of the least costly therapeutic equivalent. States apply Federal upper limits on an aggregate basis.

For drugs not subject to the FUL program, the payment limit is the lower of the pharmacy's usual and customary charge to the general public or the estimated acquisition cost (EAC) of the drug plus a dispensing fee. Most States calculate the EAC as the Average Wholesale Price (AWP) minus a percentage. The AWP is the published price charged by wholesalers to retail pharmacists.

Explanation of Provision.—(a) Drug deductible.—No payment would be made until the enrollee has met the annual drug benefit deductible.

The deductible would be set at \$500 in 1994 dollars, indexed between 1994 and 1998 to the average annual percentage increase in private sector per capita outpatient prescription drug expenditures, and indexed in subsequent years by the percentage increase in the class of prescription drug services, as specified in Title VIII of this Act.

(b) Out-of-pocket limit.—The out-of-pocket limit would be \$1,000 in 1994 dollars, indexed between 1994 and 1998 to the average annual percentage increase in private sector per capita outpatient prescription drug expenditures, and indexed in subsequent years

by the percentage increase in the class of prescription drug services, as specified in Title VIII of this Act.

(c) Payment amounts and administrative allowance.—Payments would be made at 80 percent of the lesser of the actual charge for the drug or the payment limit if the beneficiary has met the deductible and 100% if the beneficiary has met the deductible and the out-of-pocket limit.

There would be mandatory assignment for all covered outpatient drugs. The administrative allowance in 1996 would be \$5 per prescription and for succeeding years would be updated annually by the Consumer Price Index. The Secretary would be permitted to reduce the Medicare administrative allowance for drugs dispensed through a mail-order pharmacy, after consulting with representatives of pharmacists, individuals enrolled in Medicare, and private insurers. No dispensing fee would be paid for erythropoietin (EPO) provided to beneficiaries by dialysis facilities or a supplier of home dialysis supplies and equipment, for drugs provided incident to a physician's service, for antigens provided by a physician, or for covered home infusion drugs.

(d) Payment limits.—The provision would provide for the establishment of payment limits for prescription drugs under Medicare Parts B and C. In the case that the Secretary imposes maximum payment limits on services covered under private health insurance, maximum payment limits would be established for prescription drugs.

The Medicare limits would vary depending upon whether the drug is a single-source or a multiple-source drug with a restrictive prescription, or a multiple-source drug without a restrictive prescription. The limits would be updated subject to the percentage increase determined under Title VIII of this Act for the class of services that includes prescription drugs.

A drug would have a restrictive prescription only if: (i) in the case of a written prescription, the prescription of the drug indicates, in the handwriting of the physician or other person prescribing the drug, that a particular drug product must be dispensed; or (ii) in the case of a prescription issued by telephone, the physician or other person prescribing the drug states that a particular drug product must be dispensed and the physician or other person submits a written confirmation to the pharmacy involved within 30 days after the date of the telephone prescription.

The payment limit for a single-source drug, and for a multiple-source drug with a restrictive prescription would be the sum of an administrative allowance plus the estimated acquisition cost. The estimated acquisition cost for the initial payment limit would be determined by the Secretary based on information from the period beginning in 1994, updated between 1994 and 1998 by the consumer price index. For subsequent payment periods, the payment limit would be updated subject to the percentage increase determined under Title VIII of this Act for the class of services that includes prescription drugs.

In the case of a multiple-source drug without a restrictive prescription, the payment limit would be the administrative allowance plus the unweighted median of the estimated acquisition cost for the drug. For both the initial payment period and for subsequent

payment periods, the Secretary would determine the estimated acquisition cost based upon the most recent year for which data are available.

The estimated acquisition cost could not be greater than 93 percent of the published average wholesale price for the drug during the previous period. In determining the estimated acquisition cost, the Secretary could conduct surveys of wholesalers and direct sellers or use published average wholesale prices. If a wholesaler or direct seller refused, after being requested by the Secretary, to provide price information or deliberately provided information that is false, he or she would be subject to a civil money penalty of an amount not to exceed \$10,000 for each refusal or provision of false information.

Information disclosed by a wholesaler or direct seller to enable the Secretary to determine the estimated acquisition cost would be confidential and could not be disclosed by the Secretary or a contractor, except as the Secretary determines to be necessary to carry out this section and to permit the Comptroller General to review the information provided.

Effective Date.—January 1, 1998.

Sec. 8. Rebate Requirement for Medicare

Present Law.—No provision in Medicare. Under Medicare the Omnibus Budget Reconciliation Act of 1990 required that drug manufacturers, as a condition of coverage of their prescription drug products, agree to pay State Medicaid programs rebates for drugs dispensed and paid for on or after January 1, 1991. In setting the amount of required rebates, the law distinguishes between two classes of drugs: (i) single-source drugs and innovator multiple-source drugs; and (ii) all other, “non-innovator” multiple-source drugs.

For single-source drugs and innovator multiple-source drugs, manufacturers are required to pay State Medicaid programs a basic rebate for each covered drug as well as an additional rebate if drug product prices increase faster than inflation. The basic rebate amount is the greater of 15.4 percent of the average manufacturer price (AMP) for a drug or the difference between AMP and the manufacturer’s “best price” for that drug with no maximum rebate.

For multiple-source drugs, basic rebates are a fixed percentage of the AMP (10 percent in 1991 through 1993, and 11 percent beginning in 1994). There are no additional rebates for excess price increases.

To allow the calculation and monitoring of rebate amounts, drug manufacturers must report their average manufacturer price (AMP) and, in addition, manufacturers must report their “best price” for each covered drug to the Secretary on a quarterly basis. Manufacturers are subject to civil monetary penalties for false reporting.

The calculation of the AMP excludes: (i) sales to hospitals, HMOs and wholesalers where the drug is relabelled under the distributors national drug code (NDC) number; (ii) federal supply schedule prices; (iii) prompt payment discounts; and (iv) any goods or items given away, but not contingent upon any purchase requirements.

The calculation of best price does not include: (i) any prices charged to the Indian Health Service, Department of Veteran's Affairs, State homes receiving funds under Section 1741 of Title 38 of the United States Code (USC), the Department of Defense and the Public Health Service; (ii) prices charged under the Federal Supply Schedule of General Services Administration; (iii) prices under a State pharmaceutical assistance program; and (iv) any depot prices and single award contract prices of any agency of the Federal government.

Explanation of Provision.—In order for payment to be available under Medicare for covered outpatient prescription drugs, the manufacturer would be required to enter into and have in effect a rebate agreement with the Secretary. Rebates would be paid on a quarterly basis and calculated for each dosage, form and strength of a drug.

The amount of the rebate for single-source and innovator multiple-source drugs would be 15 percent of the average manufacturer retail price. The amount of the rebate for noninnovator multiple-source drugs, over-the-counter insulin, and enteral nutrients would be 10 percent of the average manufacturer retail price.

The term single-source drug and innovator multiple-source drug has the same meaning as used in the Medicaid program. The term single-source drug means a covered outpatient drug which is produced or distributed under an original new drug application (NDA) approved by the FDA, including a drug product marketed by a cross-licensed producer or distributor operating under the NDA. The term innovator multiple-source drug means a multiple-source drug that was originally marketed under an original NDA approved by the FDA.

The average manufacturer retail price is the price paid to manufacturers for drugs distributed to the retail pharmacy class of trade. The average manufacturer non-retail price is the weighted average price paid to manufacturers by hospitals and other institutional purchasers that purchase drugs for institutional use and not for resale.

The Secretary would have the authority to verify the average manufacturer retail and non-retail price. If manufacturers refused to provide this information or provided false information, civil money penalties could be imposed by the Secretary.

Information disclosed by a manufacturer to enable the Secretary to verify the average manufacturer retail and non-retail price would be confidential and could not be disclosed by the Secretary or a contractor, except as the Secretary determines to be necessary to carry out this section and to permit the Comptroller General to review the information provided.

An additional rebate for single-source and innovator multiple-source drugs would be remitted to the Secretary if the average manufacturer retail price for a covered drug of the manufacturer exceeds the average manufacturer retail price for the base period, increased by the percentage increase in the Consumer Price Index. The additional rebate would be equal to the excess increase in price above the Consumer Price Index.

Effective Date.—January 1, 1998.

Sec. 9. Related Requirements for Covered Outpatient Drugs

Present Law.—(a) Use of carriers, fiscal intermediaries, and other entities in administration.—Medicare claims are processed by private entities under contract with the Secretary. These entities are known as fiscal intermediaries under Part A and carriers under Part B. They are generally private insurance companies. Under Medicaid, States may also use fiscal agents to process claims.

(b) Administrative simplification.—Under Medicaid, each State agency is encouraged to establish as its principal means of processing prescription drug claims, a point of sale (POS) electronic claim management system for the purpose of performing on-line, real-time eligibility verification, claims data capture, adjudication of claims and, assistance to pharmacists in applying for and receiving payments. In 1991 and 1992, State expenditures for such systems received Federal financial participation at a matching rate of 90 percent if the State acquired the most cost-effective system.

(c) Assuring appropriate prescribing and dispensing practices.—Under Medicaid, States must provide for a drug use review program to assure that prescriptions are appropriate, medically necessary and are unlikely to produce adverse effects. Prospective drug use review (including counseling) must be performed before prescriptions are filled or delivered, typically at the point of sale or distribution, and must include screening for drug interactions, incorrect dosage or duration, or clinical abuse. Retrospective drug utilization review must be performed through the State's mechanized drug claims processing system to identify patterns of fraud, abuse or inappropriate care.

OBRA '93 included a provision which would permit States to operate prescription drug formularies meeting certain requirements. Most States also set minimum and maximum levels for the quantity dispensed and the frequency with which prescriptions may be filled.

Eleven States currently collect and analyze information on the prescribing, dispensing, and purchasing of selected controlled substances.

(d) Pharmacies.—Under Medicaid, pharmacies are considered providers, and as such must sign provider agreements. Pharmacists are also required to provide counseling to recipients regarding appropriate use of medications.

(e) Discounts.—No provision.

Explanation of Provision.—(a) Use of carriers, fiscal intermediaries, and other entities in administration.—The provision would authorize the use of contracts with entities other than carriers and fiscal intermediaries to administer and manage benefits for covered outpatient drugs. The functions of contractors would be amended to include the provision of information to pharmacies as to whether a beneficiary has met the annual deductible and out-of-pocket limit. Payment under such contracts would not be restricted to being on a cost basis. The contractors also would process the claims of the Railroad Retiree system.

(b) Administrative simplification.—Pharmacists would submit claims to Medicare contractors through a point-of-sale electronic system, which would be consistent with the standards established

by the National Council of Prescription Drug Programs (NCPDP). The Secretary would develop in consultation with NCPDP, representatives of pharmacies, and other interested persons, a standard claim form for covered outpatient drugs in accordance with the requirements Title IX of this Act relating to administrative simplification. The Secretary would establish a payment cycle for pharmacies providing benefits under the program. If claims were not paid within five working days of the day that payment is required to be made under the payment cycle established by the Secretary, interest would be paid as of the end of such five-day period at the rate of interest used for other late Medicare payments.

The Secretary would provide technical assistance as the Secretary determines may be necessary for pharmacies to submit claims electronically.

(c) Assuring appropriate prescribing and dispensing practices.—The Secretary would be responsible for overseeing the development of a program to assure appropriate prescribing and dispensing practices under Medicare. The program would provide for prospective review of prescriptions, retrospective review of claims, and standards for counseling individuals receiving prescription drugs. The program would include any elements of the State drug use review programs required under section 1927 of the Social Security Act that the Secretary determines to be appropriate.

The program would be designed to educate physicians, patients, and pharmacists concerning: (i) instances or patterns of unnecessary or inappropriate prescribing or dispensing practices; (ii) instances or patterns of substandard care with respect to such drugs; (iii) potential adverse reactions; and (iv) appropriate use of generic products.

The program would provide for on-line prospective review of drug therapy before each prescription is filled or delivered to an individual receiving benefits under Medicare. The review by a pharmacist would include screening for potential drug therapy problems due to therapeutic duplication, drug-drug interactions, and incorrect drug dosage or duration of drug treatment. The Secretary would develop public domain software which could be used by pharmacies to provide on-line prospective review.

The Secretary would be required to study the feasibility and desirability of requiring patient diagnosis codes on prescriptions and the feasibility of expanding prospective drug utilization review to include the identification of drug-disease contraindications, interactions with covered outpatient prescription drugs and over-the-counter drugs, and drug-allergy interactions.

As part of prospective drug use review, any individual that dispenses a prescription drug would be required to offer to discuss with each individual receiving benefits, or the caregiver of such individual (in person, whenever practicable, or through access to a telephone service which is toll-free for long-distance calls), information regarding the appropriate use of a drug, potential interactions between the drug and other drugs dispensed to the individual, and other matters established by the Secretary.

The Secretary would require advance approval for a covered outpatient drug if the drug is subject to misuse or inappropriate use. The Secretary would be required to develop and update a list of

drugs, which the Secretary determined, based on data collected, may be subject to misuse or inappropriate use. The Secretary would be required to provide a means for manufacturers to appeal an initial decision to list a drug as a drug subject to misuse or inappropriate use.

The Secretary would be required to study the feasibility and desirability of mandating advance approval in cases where a more cost-effective therapeutically equivalent drug is available.

The Secretary could not deny the approval of a drug before its dispensing unless the system providing for such approval: (i) provided responses by telephone or other telecommunication device within 24 hours of a request for prior authorization; and (ii) provided for the dispensing of at least a 72-hour supply of a covered outpatient prescription drug in emergency situations.

In addition to on-line prospective review the program would provide for the ongoing periodic examination of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care, among physicians, pharmacists and individuals receiving benefits.

The Secretary could waive the application of any provision of this subsection to the dispensing of covered outpatient drugs by a managed care organization with a contract under section 1876 or 1833(a)(1)(A) or 1876 of the Social Security Act if the Secretary finds that the organization has in effect a prescription drug review program that meets the objectives of this subsection.

The Secretary would provide for an educational outreach program to educate physicians and pharmacists on common drug therapy problems. The Secretary would provide for written, oral or face-to-face communications which provide information and suggested changes in prescribing or dispensing practices.

Information on the prescribing of scheduled II through V controlled substances would be reported electronically to the State health agency by pharmacists, physicians and others dispensing these substances.

Health care providers, pharmacists and any other individual would be required to report to the Secretary information relating to death or a serious injury (including initial or prolonged hospitalization, impairment, damage or disruption in a patient's body function, congenital anomaly, or life-threatening outcome) resulting from prescribing, dispensing, or administering a drug under Medicare. Standards would be established to protect from public disclosure the identity of individuals or institutions reporting such information, patients, or other individuals involved.

(d) Pharmacies.—Pharmacies would be required to obtain supplier numbers from the Secretary. Such supplier numbers would only be provided to pharmacists who met requirements specified by the Secretary. Pharmacies would be required to meet standards of participation including, but not limited to, maintenance of patient records, claims submission at point-of-sale, patient counseling, and performance of required drug utilization review activities.

The Secretary of Health and Human Service would be required to develop, in consultation with actively practicing pharmacists, a payment methodology for professional services provided by pharmacists. In developing a payment methodology the Secretary would

consider the reasonable charges for the varying levels of pharmacist services, including patient consultation provided to individuals under the bill. In developing the payment methodology the Secretary would not consider the administrative allowance. The Secretary would submit a report to Congress on or before September 30, 1997 regarding such recommendations as the Secretary determines are appropriate.

(e) Discounts.—As part of the rebate agreement, a manufacturer would be required to guarantee that the manufacturer would offer the same price, to each wholesaler or retailer (or other purchaser representing a group of such wholesalers or retailers) that purchases drugs on substantially the same terms (including terms such as prompt payment, cash payment, volume purchase, single-site delivery, the use of formularies by purchasers, and any other terms effectively reducing the manufacturer's costs) as any other purchaser (including any institutional purchaser). In determining compliance the terms offered to the Department of Veterans Affairs, the Department of Defense, or any other public program would not be taken into account.

Effective Date.—January 1, 1998.

Sec. 10. Prescription Drug Payment Review Commission

Present Law.—No provision.

Explanation of Provision.—The Director of the Office of Technology Assessment (OTA) would appoint an eleven-member Prescription Drug Payment Review Commission within one year of enactment. Members would be composed of individuals with experience in the provision and financing of covered outpatient drugs and would include experts in the field of health care economics, medicine, pharmacology, pharmacy, and prescription drug reimbursement, as well as at least one Medicare beneficiary and one representative from a research-based pharmaceutical or biotechnology company.

The Commission would submit an annual report to Congress regarding the prices of prescription drugs, increases in drug prices, use of covered drugs, and administrative costs relating to covered drugs.

The Commission would be required to examine drug costs in relation to other therapies. In addition, the Commission would be required to publish a consumer guide to prescription drugs annually. The consumer guide would include information which the Commission determines: (i) would assist consumers in reducing their expenses for prescription drugs; and (ii) would assist providers in determining the most cost effective drug to prescribe. The Commission could charge a reasonable fee for providing a guide to consumers and providers.

The Commission would submit annual recommendations to the Congress regarding payments for prescription drugs under the national health expenditure estimates, including recommendations on the allocation of the national expenditure estimates to the prescription drug sector.

Effective Date.—January 1, 1998.

Sec. 11. Adjustment in the Part B Premium

Present Law.—Individuals enrolled in Part B pay a monthly premium. The premium is currently set to cover 25 percent of program costs for aged beneficiaries. The remaining 75 percent is covered by general revenues.

Explanation of Provision.—The provision would provide for a special add-on to the Part B premium to finance the same percentage of the cost of the drug benefit through premiums as is financed through premiums for other Part B benefits.

Payments for benefits would be administered through the Part B trust fund.

Effective Date.—January 1, 1998.

Sec. 12. Home Infusion Drug Therapy Services

Present Law.—Medicare provides partial coverage for home infusion drug therapy services. Medicare covers home parenteral and enteral nutrition under the prosthetic device benefit and Medicare carriers have the discretion to cover home infusion drugs if infusion therapy pumps (which are categorized as durable medical equipment) are used in a patient's treatment.

Explanation of Provision.—Only qualified home infusion drug therapy providers would qualify to provide covered home infusion drug therapy services. A qualified home infusion drug therapy provider would include any entity that the Secretary determined met the following requirements: (i) the entity is capable of providing or arranging for home infusion drug therapy services and covered home infusion drugs; (ii) the entity maintains clinical records on all patients; (iii) the entity adheres to written protocols and policies with respect to the provision of items and services; (iv) the entity makes services available (as needed) seven days a week on a 24-hour basis; (v) the entity coordinates all services with the patient's physician; (vi) the entity conducts a quality assessment and assurance program, including drug regimen review and coordination of patient care; (vii) the entity assures that only trained personnel provide covered home infusion drugs (and any other service for which training is required to provide the service safely); (viii) the entity assumes responsibility for the quality of services provided by others under arrangements with the entity; and (ix) the entity meets such other requirements as the Secretary may determine are necessary to assure the safe and effective provision of home infusion drug therapy services.

The Secretary would determine which of the above requirements would apply to home health agencies that provide home infusion drug therapy services and to home infusion therapy providers that furnish only enteral nutrition therapy services.

Home infusion drug therapy services would be required to be provided in the place of residence used as the individual's home or in another setting determined by the Secretary to be cost effective and under a plan established and reviewed by a physician. Home infusion drug therapy services would include such nursing, pharmacy, and related services (including medical supplies, intravenous fluids, delivery, and equipment) as are necessary to conduct safely and ef-

fectively a drug regimen through the use of a covered home infusion drug.

State agencies would certify that home infusion drug therapy providers met the standards established by the Secretary. Payment for home infusion drug therapy services would be based on the fee schedule amount established by the Secretary.

Effective Date.—January 1, 1998.

Sec. 13. Other Changes in Medicare Benefits

Present Law.—Federal law establishes uniform benefits to be covered under Medicare. These benefits are described generally in Subtitle A of this Title.

(a) Cap on out-of-pocket expenditures.—There is no upper limit on beneficiary cost-sharing with respect to Medicare covered services.

(b) Limit on lifetime reserve days.—Medicare provides coverage for up to 90 days of inpatient hospital care during a “spell of illness” subject to a deductible (\$696 in 1994, increased annually). A daily copayment is applied to the 61st through the 90th day (\$174 per day, in 1994, increased annually). A one-time lifetime reserve of 60 days is provided if an individual exceeds 90 days in a benefit period. These lifetime reserve days are subject to a daily copayment (\$348 per day, in 1994, indexed annually). Inpatient hospital benefits are not covered under Medicare after the lifetime reserve days are exhausted.

(c) Newborn, well-baby and well-child services.—Medicare does not generally cover well-baby and well-child preventive services. Medicare covers outpatient rehabilitation services, including but not limited to outpatient physical therapy, occupational therapy and speech pathology services and comprehensive outpatient rehabilitation facility services, when such services which are reasonable and necessary to treat an illness or injury, without explicit exclusion of treatment for children with congenital conditions.

(d) Preventive benefits.—Medicare covers pap smears to screen for cervical cancer, mammography to screen for breast cancer, pneumococcal vaccines, and hepatitis B vaccines for certain high-risk individuals.

Medicare covers mammography screening based upon the following schedule: a baseline exam for women between the ages of 35 and 39; an exam once per 23-month period following an exam for women between the ages of 40 and 49 (or once per 11-month period high-risk women in this age group); once per 11-month period following an exam for women between the ages 50 and 64, and once per 23-month period following an exam for women ages 65 and older.

Medicare coverage for pap smears is limited to once every three years, with more frequent pap smears allowed for women at high risk of developing cervical cancer.

(e) Coverage of chiropractic services.—Medicare coverage of chiropractic services is limited to treatment by means of manual manipulation of the spine to correct a subluxation of the spine demonstrated by x-ray to exist; however, Medicare does not cover x-rays performed by chiropractors necessary to demonstrate the existence of the subluxation of the spine.

(f) Pregnancy-related services and family planning.—No provision.

(g) Mental health and substance abuse.—(i) Medicare inpatient psychiatric benefit.—Medicare payments for inpatient psychiatric hospital services are limited to 190 days during a patient's lifetime. The limitation applies only to services provided in a psychiatric hospital.

Inpatient substance abuse services, and services consistent with alcohol detoxification or treatment for drug or chemical withdrawal, are covered.

(ii) Intensive residential services.—No provision.

(iii) Intensive community services.—Partial hospitalization services are covered under Medicare to individuals who would otherwise require inpatient psychiatric care.

(iv) Outpatient mental health and substance abuse benefits.—Medicare Part B pays 50 percent of the recognized payment amount for outpatient psychotherapy services, which can include treatment for problems associated with drugs or alcohol, for an individual who is not an inpatient of a hospital.

(v) Special requirements for services provided to children and adolescents through organized systems of care.—No provision.

(vi) Comprehensive managed mental health and substance abuse programs.—No provision.

(vii) Advisory commission on mental health and substance abuse services.—No provision.

(h) Managed care options.—Medicare beneficiaries may choose to enroll in an eligible organization that contracts with Medicare under section 1876 of the Social Security Act. Under such contracts, eligible organizations provide Medicare benefits in exchange for a premium, paid in part by Medicare and in part by enrolling beneficiaries. Services must be provided either directly by the organization or through arrangements made by the organization. A beneficiary enrolled in an organization is not covered (either by the organization or by Medicare) for services provided outside the organization or its arrangements.

Explanation of Provision.—Medicare would continue to provide benefits under Parts A and B, subject to current law deductibles and coinsurance requirements. In addition to the outpatient prescription drug benefit and the mental health benefit described in the preceding section, the current Medicare benefit package would be improved to include a cap on out-of-pocket expenditures and to remove the limit on lifetime reserves days for inpatient services, and to add newborn services, well-baby services, well-child services, pregnancy-related services, family planning services, drugs and devices, and additional preventive services.

(a) Cap on out-of-pocket expenditures.—A new cap on out-of-pocket expenditures would be set at \$5,500 per beneficiary (in 1994 dollars), for all items and services covered under Medicare Parts A and B other than outpatient prescription drugs, beginning January 1, 2003. The cap would be indexed between 1994 and 1998 to the nominal growth in per capita gross domestic product, and indexed in subsequent years to the rate of growth in Medicare per capita spending, as specified in Title VIII of this Act.

(b) Limit on lifetime reserve days.—The 60-day limit on lifetime reserve days would be eliminated. The coinsurance requirements that apply to lifetime reserve days would be retained. The Secretary would be authorized to make any necessary adjustments in payments to hospitals to take into account the elimination of the lifetime reserve day limit.

(c) Newborn, well-baby and well-child services.—Newborn, well-baby and well-child services for children to age 19 would not be subject to deductibles or other cost-sharing requirements. Newborn and well-baby care would be consistent with the service and periodicity schedule specified by the Secretary, in consultation with the American Academy of Pediatrics.

Medicare would be modified to cover pediatric attendance at high-risk deliveries.

Well-child services, including routine office visits, routine immunizations, routine lab tests, and dental care, would be covered and would be consistent with the services and periodicity schedule specified by the Secretary, in consultation with the American Academy of Pediatrics. Well-child services would be defined to include periodic lead screening and child abuse assessment.

Coverage of outpatient rehabilitation services would be clarified in statute to include treatment for children with congenital conditions, provided other requirements are met.

(d) Preventive benefits.—The following improvements would be made to expand Medicare coverage of preventive benefits.

Medicare coverage of mammography screening would be modified to cover mammograms once per 11-month period for women ages 65 and older following the month in which a screening mammography was performed.

The schedule for pap smears would be modified to cover an annual pap smear and pelvic exams for women who have reached childbearing age, until negative results appear for three consecutive years, with one pap smear and pelvic exam covered per three-year period thereafter. Women at high risk of developing cervical cancer would be covered on an annual basis. Clinical breast exams would be covered, based upon the schedule set forth for pap smears.

Colorectal screening would be added as a benefit to Medicare and would be covered under the national guaranteed benefit package, with coverage of fecal occult blood tests (FOBT), screening sigmoidoscopies for the early detection of colorectal cancer, and screening colonoscopies. The FOBT would be covered on an annual basis. The screening sigmoidoscopies would be covered once per five-year period. Screening colonoscopies would be covered on a periodic basis for high-risk individuals as defined by the Secretary.

(e) Coverage of chiropractic services.—Coverage of chiropractic services would be modified to include the x-ray services necessary to determine the existence of the subluxation of the spine.

(f) Pregnancy-related services and family planning.—All pregnancy-related services would be covered. Pre-natal services would be covered without cost-sharing requirements. Family planning would be covered, including voluntary planning services and contraceptive drugs and devices.

(g) Mental health and substance abuse.—(i) Medicare inpatient psychiatric benefit.—The Medicare inpatient psychiatric benefit would be amended to limit inpatient psychiatric hospitalization to a yearly limit of 60 days in general and psychiatric hospitals. The 190-day lifetime limit is eliminated.

An individual who at any date prior to January 1, 1998, has utilized inpatient psychiatric services for 190 consecutive days is not entitled to inpatient and residential mental health services provided through Medicare. These individuals can continue to be managed under a State's long term Medicaid program.

(ii) Intensive residential services.—Coverage would be provided in the following residential programs: (a) residential detoxification centers; (b) crisis residential programs or mental illness residential treatment programs; (c) therapeutic family or group treatment homes; (d) centers for substance abuse.

These services would be available for up to 120 days per year; however, residential services may be substituted for inpatient services as long as the residential services do not exceed the cost in an inpatient setting estimated for an individual to complete treatment. The Secretary will be directed to develop standards for the appropriate management of all intensive residential services.

(iii) Intensive community services.—The following intensive community services would be covered for a maximum of 90 days per year and with a 20 percent copayment: (a) psychiatric rehabilitation services; (b) behavioral aide services; (c) in-home services; (d) ambulatory detoxification. Day treatment services for children would be covered for 180 days per year with a 20 percent copayment, with no trade-off for inpatient hospital days. Case management services would be covered without limits or copayments for seriously emotionally disturbed children and adults with serious mental illness. The Secretary would be directed to develop standards for the appropriate management of these services.

The term "intensive community-based services," either facility-based or free-standing, includes partial hospitalization. These services would be provided as an alternative to hospitalization as well as to prevent relapse which can lead to hospitalization. These services would be provided through programs meeting applicable State certification or private accrediting standards. Services would be provided under the supervision of a physician or non-physician mental health professional licensed by the State, provided that such supervision is not prohibited by the scope of practice of the non-physician mental health professional. Services would be provided pursuant to an individualized, written plan of treatment established and periodically reviewed by a physician in consultation with a treatment team consisting of appropriate staff participating in such program.

Assessment, diagnosis and entering patients into intensive community based services can be conducted independently by licensed mental health professionals to the extent permitted by State law. It is the intent of the committee to recognize the interdisciplinary and collaborative aspects of treatment provided in these settings.

(iv) Outpatient mental health and substance abuse benefits.—The outpatient psychotherapy benefit would be amended to include psychotherapy sessions for children and adolescents (through age

18) with a 20 percent copayment. The initial five adult outpatient psychotherapy sessions would be covered with a 20 percent copayment.

(v) Special requirements for services provided to children and adolescents through organized systems of care.—Requirements would be consistent with those defined in the guaranteed national benefit package.

(vi) Comprehensive managed mental health and substance abuse programs.—Medicare beneficiaries would have access to managed mental health and substance abuse programs, as defined in the guaranteed national benefit package.

(vii) Advisory commission on mental health and substance abuse services.—A Commission would be established, consistent with the provision described in the guaranteed national benefit package.

(h) Managed care options.—Managed care options would be expanded for Medicare beneficiaries. The Secretary would be authorized to contract with eligible organizations to provide Medicare benefits under a point-of-service plan. Under a point of service plan, the organization contracting with the Secretary would provide services directly or through arrangements as under present law, and would also provide coverage when a beneficiary elects to receive services outside of the organization or its arrangements. In no case could the cost-sharing requirements imposed on a beneficiary electing to receive services outside the organization exceed the cost-sharing requirements that would otherwise be imposed on a fee-for-service basis under Medicare.

Effective Date.—The modifications to Medicare Parts A and B would be effective for items and services provided on or after January 1, 1998, with an exception for the cap on out-of-pocket spending which would apply for items and services provided on or after January 1, 2003.

Title IV. State Responsibilities

Sec. 1. Establishment of State Programs

Present Law.—Under the Medicare program the Secretary may provide that payments to hospitals in a State be made in accordance with a State hospital reimbursement control system. Currently, the Secretary has so provided with respect to the State of Maryland and with respect to several counties in the Finger Lakes region of New York State.

Explanation of Provision.—The Secretary's approval would be granted for two types of State programs. Under one authority, a State could establish a provider reimbursement system, either for all health care services in the State or only for particular classes of services. For example, a State could establish an all-payer provider reimbursement system for hospital services only, physician services only, or for all health care services. Alternatively, a State could establish a benefit management program, under which the State would have authority over all health care benefits provided in the State.

In general, employers would be required to participate in an approved State program, either an all-payer provider reimbursement system or a benefit management program.

An exception to the general requirement would be provided with respect to a State benefit management program. Under the exception, any employer (or multiemployer plan) that (i) sponsors a self-insured health plan meeting the requirements for such plans under Title V, (ii) has a total of at least 5,000 employees nationally, and (iii) has employees located in at least two States, would not be required to participate in an approved State benefit management program. All employers and sponsors of self-insured plans would, however, be required to participate in approved State provider reimbursement systems.

In the case of either type of program, the Secretary would approve State programs if all applicable requirements were met. The Federal cost containment system that could otherwise apply to providers, described in Title VI, would not apply to providers in States with approved programs.

Effective Date.—Effective upon the date of enactment.

Sec. 2. Standards for State Provider Reimbursement Systems

Present Law.—(a) Requirements for approval.—Under the Medicare program the Secretary may provide for reimbursement under a State hospital reimbursement control system if the Governor of the State so requests and the Secretary: (i) finds that the system applies to substantially all non-Federal acute care hospitals in the State and to at least 75 percent of all inpatient hospitals revenues or expenses; (ii) is assured that the system provides equitable treatment of all payers; (iii) is assured that expenses under the system over 36-month periods will not exceed payments which otherwise would have been made under Medicare; (iv) determines that the system will not preclude HMOs from negotiating directly for payment of hospitals; and, (v) determines that the system requires hospitals to comply with Medicare requirements regarding payment for unneeded care.

For States which set Medicare payments through a State hospital reimbursement control system as a demonstration under the authority of the Social Security Amendments of 1967 and 1972, the Secretary is required to judge the effectiveness of the system based upon the State's rate of increase in inpatient hospital payments as compared to the national rate of increase. For states with a reimbursement control system in continuous operation since July 1, 1977, the test of compliance is based on the period since January 1, 1981 to the most recent year for which data are available.

(b) Termination of approval.—In general, the Secretary may terminate approval of a State hospital reimbursement control system under Medicare if the Secretary finds that the system no longer meets the standards described in subtitle B. If the Secretary determines that the assurances regarding maintaining payments over a 36-month period below the level of payments which Medicare would otherwise make have not been met, the Secretary may reduce payments under Medicare in an amount equal to the amount of the excess payments which the hospitals received under the State system.

(c) Interim adjustments in Medicare payments.—No provision.

(d) Use of Medicare savings.—No provision.

Explanation of Provision.—(a) Requirements for approval.—States would be required to establish payment rates which would apply to all services furnished in a State that are covered under the State system, regardless of payer.

Approval of a State provider reimbursement system by the Secretary would be deemed to be approved for participation by Medicare and Medicare part C in the State system. Hospital payment systems operated by States under existing Medicare waiver authority would be deemed to meet the requirements of this title. States would continue to operate these systems subject to the requirements under current law.

States seeking approval for a system would be required to demonstrate to the Secretary that the system would meet two tests. Each test would be applied on a 36-month rolling average basis, beginning with the first month the system is in effect in a State, except that in no case would the initial 36-month period begin earlier than January 1, 1997.

Under the first test, total expenditures in the State for the services covered under the State system could not exceed expenditures that would have been made if the State system were not in effect. Under the second test, total Medicare expenditures (including Medicare part C) for services covered under the State system could not exceed total Medicare expenditures that would have been made if the State system were not in effect.

The Secretary would annually determine whether a State system has met each of the required tests.

In addition, States would be required to provide assurances that the operation of the system would not reduce access by individuals to services covered under the system.

State systems would be required to provide for equitable treatment of payers, although payment differentials would be authorized for payment under the Medicaid program, as long as the ratio of payments under Medicaid relative to payments under private health plans is not less than the ratio in the year prior to implementation of the State system. States could provide for negotiated rates for HMOs, but could specify minimum payment rates for all payers.

With respect to equitable treatment of payers, the Committee intends that State systems may provide payment differentials among payers as long as the differentials are based on objective criteria, such as differences in cost due to differences in enrollment practices or other objective criteria.

State systems would be required to be publicly administered, which would not preclude a State from contracting with private organizations to carry out the requirements of the State system.

States would be required to file an initial application, annual reports, and other reports requested by the Secretary to monitor and evaluate the system.

(b) Termination of approval.—The Secretary would terminate a State system if the Secretary determines that a State has not met either of the required tests, or if the State fails to meet other requirements for approval of a State provider payment system.

If the requirements were not met by a State, the Secretary would provide the State with 90-days notice of the intention to reinstate

the Federal private sector cost containment system and reinstate Medicare payments in the State. The State could request a hearing to review this finding. No administrative or judicial review of a determination by the Secretary to terminate approval of a State system would be permitted.

The Secretary would make adjustments to the maximum payment rates (under the Federal private sector cost containment system established in Title VI) that could apply to services that had been covered under the State system in the case of a State that failed the test regarding total expenditures in a State. The Secretary would adjust Medicare payment rates for services that had been covered under the State system to recoup any excess Medicare spending in a State if the State failed the test regarding Medicare expenditures.

Adjustments would be made during the first year after termination of the system, or, if the Secretary determines it is appropriate, over a three-year period beginning in the first year after termination of the system.

(c) Interim adjustment in Medicare payments.—During the first three years of the operation of a State program, the Secretary could, at the Secretary's discretion, upon thirty days notice, reduce payments on behalf of the Medicare program to a State or to health care providers in a State in order to ensure that Medicare spending does not exceed the targets otherwise provided.

In the case of a finding by the Secretary that payments to a State or to providers in a State should be reduced, the Secretary would hold any payments in dispute until either the State provides evidence to the satisfaction of the Secretary that the State was in compliance with spending requirements, or approval for the State plan was withdrawn by the Secretary, in which case the funds would revert to the Medicare program.

(d) Use of Medicare savings.—If the Secretary determined that a State system produced savings to the Medicare program over a period of three consecutive years, the Secretary would pay the savings attributable to the first year of that period to the State in the following year.

Effective Date.—Effective upon the date of enactment.

Sec. 3. Standards for State Benefit Management Programs

Present Law.—(a) Requirements for approval.—No provision.

(b) Requirements with respect to Medicare beneficiaries.—No provision.

(c) Payments to states.—No provision.

(d) Interim adjustment in Medicare payments.—No provision.

(e) Use of Medicare savings.—No provision.

(f) Termination of approval.—No provision.

Explanation of Provision.—(a) Requirements for Approval.—A State program for management of all health care benefits provided in the State would be required to guarantee coverage for at least the guaranteed national benefit package to, at least, all residents of the State eligible under this Act other than residents covered under Medicare Parts A through C, and excluding individuals participating in a multistate employer plan that is not required to par-

ticipate in the State benefit management program as described in section one above.

Guarantee of coverage could be through a State single payer or public plan, an employer mandate, a combination of public and private coverage, competing health plans, managed competition, or any other system, provided that it covered all residents of the State.

States would be required to assure, to the satisfaction of the Secretary, that services under the guaranteed national benefit package were reasonably accessible to all residents of the State covered under the program.

A State would be required to provide assurances to the Secretary that expenditures under the State program would meet the tests applicable to State provider reimbursements systems, except that the test regarding Medicare expenditures would only apply to the extent that the State program includes coverage of Medicare beneficiaries.

For the purposes of determining for whom a State benefit management program must provide coverage, a resident would be defined, consistent with current law definitions under Medicaid, as an individual living in the State with the intention of remaining there permanently or indefinitely. Eligibility for benefits under the State program could not be denied because an individual has not resided in that State for a specified period, or because the individual is temporarily absent from the State. A State would not be required to provide coverage under a benefit management program to individuals residing in the State substantially for the purpose of receiving medical treatment in that State.

State programs would be required to be publicly administered, which would not preclude a State from contracting with private organizations to carry out the requirements of the State program.

States would be required to file an initial application, annual reports, and other reports requested by the Secretary to monitor the program.

To the extent that a State proposed to provide benefits directly through a public plan, the public plan would be required to meet additional standards. The public plan would be required to meet the Federal standards pertaining to pre-existing condition exclusions, open enrollment, guaranteed renewal, and community rating that would be established by the Secretary with respect to private health plans. The public plan would be required to provide for coverage of out-of-state benefits, and to provide for coordination of benefits with health plans in other States. The public plan would also be required to comply with the national administrative simplification standards.

A State may not prohibit providers in the State from receiving payment for services provided to individuals enrolled in an eligible multistate self-insured plan for which the sponsor elects not to participate in the State benefit management program, or imposing other rules that restrict the ability of providers from furnishing services to these individuals.

(b) Requirements with respect to Medicare beneficiaries.—A State could apply at any time to include in the State program coverage for individuals eligible under Medicare Part C. After three

years of experience with a State program, a State could apply to integrate coverage under Medicare Parts A and B into a State-based system.

States would be required to assure, to the satisfaction of the Secretary, that all services for which Medicare beneficiaries would otherwise be eligible would be provided under the State system, without any additional cost to beneficiaries and would be reasonably accessible to all beneficiaries residing in the State.

A State that applies to include Medicare eligible individuals in the State program must ensure that these individuals would be eligible for the same benefits and provided the same opportunities with respect to choice of health plans as other residents of the State.

(c) Payments to States.—In general, in the case of a State operating a program that includes Medicare beneficiaries, the Medicare program would pay providers for services provided to Medicare beneficiaries in accordance with payment rules established by the State under the State program.

A State could elect to pay providers directly for services provided to Medicare beneficiaries in accordance with payment rules under the State program, in which case the Medicare program would reimburse the State for such services in accordance with rules established by the Secretary for such reimbursement.

A State could further elect to have Federal payments for services provided to Medicare beneficiaries that would otherwise be made on behalf of State residents to be paid directly to the State on a periodic basis.

In a State with an approved program, Federal premium subsidies would, in general, continue to be paid directly to eligible individuals. The State, could, however, elect to have payments that would otherwise be paid to eligible residents of the State with respect to premium certificates paid directly to the State on a periodic basis. In the case of a State that elects to include individuals eligible for Medicare Part C in the State program, the Secretary would make payments to the State, on a periodic basis, with respect to reductions in premiums that would otherwise be provided to individuals if they were participating in Part C.

In general, in determining payments to the States for premium certificates or Medicare Part C premium subsidies the Secretary would estimate payments that would otherwise be made to eligible individuals residing in the State in the most recent year, trended forward by the projected national growth in Federal subsidies.

In the case of a State with an approved State program in effect on or before January 1, 1998, the State would be required, for calendar year 1998, to establish a program to determine eligibility of State residents for Federal premium certificates, comparable to the Federal method of determination, and to submit information required by the Secretary to enable the Secretary to appropriately estimate payments to the State for that year for the population eligible for premium certificates.

The Secretary, using information provided by the Secretary of the Treasury, would reconcile premium certificate payments made to the State and make appropriate adjustments in future payments to the State to reflect any overpayments or underpayments.

In a State with an approved program, Federal wrap-around benefits defined under Title VIII of this Act, would continue to be provided for individuals determined to be eligible for such benefits. A State could, however, elect to have Federal payments for wrap-around benefits that would otherwise be made on behalf of State residents paid directly to the State on a periodic basis.

In such case, the State would be required to provide assurances that comparable wrap-around benefits would be provided under the State program to individuals who would be eligible for Federal benefits.

In general, in determining payments to the States the Secretary would estimate Federal wrap-around benefit as defined under Title VIII of this Act, payments that would otherwise be made by totaling payments made to individuals residing in the State in the most recent year, trended forward by the national growth in the Federal wrap-around benefits.

In the case of a State with an approved State program in effect on or before January 1, 1998, the State would be required, for calendar year 1998, to establish a program to determine the eligibility of State residents for Federal wrap-around benefits, comparable to the Federal method of determination, and to submit information required by the Secretary to enable the Secretary to estimate as appropriate payments to the State for that year.

Payments made directly to States with respect to any premium certificates, Part C subsidies, wrap-around benefits, or payments made on behalf of Medicare beneficiaries would be offset by Medicaid maintenance of effort payments owed by the State (described in Title VIII) prior to payment by the Secretary to the State.

(d) Interim adjustment in Medicare payments—During the first three years of a State program which includes Medicare beneficiaries (including Medicare part C), the Secretary could, at the Secretary's discretion, upon thirty days notice, reduce payments on behalf of the Medicare program to a State or to health care providers in a State in order to ensure that Medicare spending does not exceed the targets otherwise provided.

In the case of a finding by the Secretary that payments to a State or to providers in a State should be reduced, the Secretary would hold any payments in dispute until either the State provides evidence to the satisfaction of the Secretary that the State was in compliance with spending requirements, or approval for the State plan was withdrawn by the Secretary, in which case the funds would revert to the Medicare program.

This provision would not apply in the case of a State for which Medicare is making a periodic payment of the estimated costs associated with benefits that would have been provided to Medicare beneficiaries.

(e) Use of Medicare savings.—If the Secretary determined that a State system produced savings to the Medicare program over a period of three consecutive years, the Secretary would pay the savings attributable to the first year of that period to the State in the following year.

This provision would not apply in the case of a State for which Medicare is periodically paying the State an estimate of the pay-

ments that would otherwise be made on behalf of services provided to Medicare beneficiaries if the State program was not in effect.

(f) Termination of approval.—The Secretary would terminate a State system if the Secretary determines that a State has not met either of the required tests pertaining to health expenditures in the State, or if the State fails to meet other requirements for approval of a State benefit management program, such as the requirement that services under the guaranteed national benefit package were reasonably accessible to all residents of the State.

If the Secretary determines that the requirements were not met by a State, the Secretary would provide the State with 90-days notice of the intention to re-instate the Federal private sector cost containment system and to reinstate Medicare part A and B and Medicare part C in the State, if these programs were incorporated in the State system. The State could request a hearing to review this finding. No administrative or judicial review of a determination by the Secretary to terminate approval of a State system would be permitted.

In the case of a State benefit management program which includes Medicare parts A and B or Medicare part C, and fails to meet requirements of such programs, the Secretary would make payment for any services provided to Medicare beneficiaries which would have been paid under Medicare, but were not reimbursed under the State program.

The Secretary would make adjustments to the maximum payment rates and to Medicare payments to recoup any excess spending in the same manner as would apply under a State provider reimbursement system.

Effective Date.—Effective upon the date of enactment.

Title V. Health Plans and Health Alliances

Subtitle A. Establishment of federal standards for health plans sold to individuals and employers

Sec. 1. Establishment and Enforcement of Federal Standards

Present Law.—In general, Federal standards have not been established for health plans sold to individuals and employers. Federal standards under section 1882 of the Social Security Act apply to Medicare supplemental insurance policies. States, subject to approval by the Secretary, may enforce the standards by adopting a regulatory program approved by the Secretary as meeting the Federal requirements. In the case of a State that does not have an approved regulatory program, the Secretary enforces standards for Medicare supplemental insurance policies. Title XIII of the Public Health Service Act establishes standards for Health Maintenance Organizations that voluntarily seek Federal qualification.

Explanation of Provision.—The Secretary would promulgate, by July 1, 1995, regulations to implement Federal standards for carriers with respect to health plans sold to individuals and employers.

States would be required to adopt the Federal standards. The Secretary would certify State compliance and would assume re-

sponsibility for enforcing the standards in a State that did not comply.

States would continue to regulate financial solvency of carriers with respect to health plans sold to individuals and employers using standards at least as stringent as standards established by the National Association of Insurance Commissioners (NAIC). If within six months after the date of enactment, the NAIC establishes standards with respect to the requirements set forth below, and the Secretary approves the standards as meeting the requirements, the NAIC standards would be treated as part of the Federal standards for health plans.

Standards would be established with respect to the authority of States to examine the financial records of carriers with respect to health plans whenever necessary, to require that carriers offering health plans have and maintain a minimum level of capital and surplus to transact business and the authority to require additional capital surplus if necessary; to require carriers offering health plans to use certain accounting practices and procedures; to order a carrier to take necessary corrective action or cease practices which, if not corrected, could place the carrier or the health plan in a hazardous financial condition; to require that securities owned by plans be reduced in accordance with recognized standards; to require a diversified investment portfolio; to administer plans found to be insolvent; and to ensure the payment of claims on behalf of individual subscribers to a health plan offered by a carrier that is deemed insolvent. The standards would further provide that an individual enrolled in an insured health plan that becomes insolvent would not be liable for any payment for services beyond any cost-sharing requirements.

If the NAIC did not develop standards within the six-month time period, or the Secretary finds the standards do not meet the requirements specified above, the Secretary would be required to specify standards to meet the requirements.

The sale or issuance of a health plan not in compliance with Federal standards would be subject to civil monetary penalties. The provisions of section 1128A of the Social Security Act (other than subsection (a) and (b)) would apply. A person who sells or issues a health plan in violation of the requirement for certification would be subject to a civil money penalty not to exceed \$25,000 for each violation. A person that sells or issues a health plan in violation of the requirements pertaining to non-discrimination, open enrollment, pre-existing condition exclusions, continuation of coverage, marketing of health plans, or essential community providers would be subject to a civil money penalty not to exceed \$10,000 for each violation.

With respect to enforcing anti-discrimination requirements, the Secretary of HHS would have the authority to withhold Federal financial assistance to a State that is not in compliance with the adoption and enforcement of the Federal requirements, and to refer matters involving non-complying health plans to the United States Attorney General for further action.

State laws imposing requirements with respect to rating of health plans, market sectors, pre-existing condition exclusions and

utilization review that are inconsistent with the Federal standards under this Title would be preempted by the provisions of this Title.

Effective Date.—In general, States would be required to adopt the Federal standards effective for health plans sold to individuals and employers beginning on January 1, 1997. An exception would be provided for States in which the legislature was not scheduled to meet during calendar year 1996. These States would be required to adopt the standards effective for health plans sold to individuals and employers beginning on January 1, 1998, or the first day of the first quarter after the close of the next scheduled meeting of the State legislature, whichever is earlier.

Sec. 2. Standards and Requirements for Health Plans Sold to Individuals and Employers

Present Law.—No Federal standards have been established for carriers with respect to health plans sold to individuals and employers. Some States have established small group health insurance standards, and a few have established standards for health plans sold to individuals. States generally require that carriers offering health plans sold to individuals and employers include particular benefits and cover the provision of benefits by specific types of health care providers.

- (a) Establishment of market sectors.—No provision.
- (b) Requirement for certification.—No provision.
- (c) Non-discrimination requirements.—No provision.
- (d) Open enrollment requirements.—No provision.
- (e) Prohibition on pre-existing condition exclusions.—No provision.
- (f) Prohibition on waiting periods.—No provision.
- (g) Continuation of coverage requirements.—COBRA requires employers with 20 or more employees to provide certain employees and their families the option of purchasing continued health insurance coverage at group rates in the case of certain qualifying events. Health insurers are liable for COBRA violations if there is a written agreement with an employer providing that the insurer has assumed responsibility for COBRA-related acts.
- (h) Market exit.—No provision.
- (i) Benefit requirements.—No provision.
- (j) Community rating requirements.—No provision.
- (k) Study and development of risk adjustment methodology.—No provision.
- (l) Additional standards for managed care plans and point-of-service plans.—No provision.
- (m) Standards for marketing health plans.—No provision.
- (n) Essential community providers.—No provision.
- (o) Utilization review standards.—No provision.
- (p) Additional requirements for insured health plans.—No provision.

Explanation of provision.—(a) Establishment of market sectors.—Five separate market sectors would be established for health plans sold to individuals and employers. A carrier offering a health plan in a State could choose to offer health plans in one or more market sectors.

The five sectors would be the individual market; the small employer market, defined to include employers with 2 to 100 employees; the large employer market, defined to include employers with more than 100 employees; the association market; and the health alliance market.

The association market would include associations, religious fraternal organizations, or other organizations certified by the Secretary as having been formed for purposes other than the sale of health insurance, and with at least 1,000 individual members or 200 employer members, and which offered insurance as of December 31, 1993. Associations include trade associations, industry associations, professional associations, chambers of commerce or other public entity associations, including wholly-owned subsidiaries or corporations, if the subsidiary or corporation is wholly owned by one or more associations.

(b) Requirement for certification.—A carrier could not offer a health plan in any market sector unless the plan had been certified by the State (or by the Secretary in the case of a State for which the Secretary is enforcing the Federal standards) as meeting the standards of this Title.

Health plans subject to the certification requirement would be defined to exclude coverage only for accident, dental, vision, disability income, or long-term care insurance, or any combination thereof; Medicare supplemental insurance; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; worker's compensation or similar insurance; automobile medical-payment insurance; coverage for a specified disease or illness; a hospital or fixed indemnity policy; and coverage provided exclusively to individuals who are not eligible individuals under the Health Security Act.

(c) Non-discrimination requirements.—A carrier offering a health plan in any market sector could not deny coverage to any employer or individual due to health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability or medical condition.

A carrier would be prohibited from engaging directly or indirectly in activities, including the selection of a service area or selection of a provider network, that would have the effect of discriminating against an individual on the basis of race, national origin, religion, gender, sexual orientation, language, socio-economic status, age, health status or anticipated need for health services.

(d) Open enrollment requirements.—A carrier offering a health plan in the small employer, large employer, and association market sectors would be required to provide year-round open enrollment to any employer or association (or other eligible arrangement) in the sector.

A carrier offering coverage in the individual market would be required to participate in and advertise during an annual open enrollment period established by the State and lasting at least 45 days, during which individuals other than new market entrants could switch among health plans offered in the individual market. During an individual's first year of enrollment in the individual market, the individual could choose to switch among health plans offered outside of the annual open enrollment period. The individ-

ual would be required to give 45-days notice before the effective date of the change in health plans could take effect, and the individual could make such a change only once within the year. After the first year of enrollment, changes could only be made during the open enrollment period.

A carrier offering coverage in the individual market could not deny coverage at any time to an individual who is a new entrant to the individual market, and could elect to provide continuous open enrollment for any individual seeking coverage.

A carrier offering a health plan in the association sector could restrict enrollment to members of the association. A carrier that is also an association, religious fraternal benefit society or other organization certified by the Secretary as described above could restrict enrollment to members of the organization if the carrier meets the other requirements of this Title.

A carrier offering a managed care plan could apply to the State (or the Secretary in the case of a State for which the Secretary is enforcing the Federal standards) to close enrollment in the plan in all or part of its service area if the carrier demonstrates that the plan has reached its capacity to absorb new members.

A transitional rule would provide for exceptions to the open enrollment requirement. A carrier offering a health plan in the individual market prior to January 1, 1998, could refuse to enroll an individual in a health plan, except during an annual 30-day open enrollment period during which the plan would be required to provide for enrollment of any individual and for which the plan would be required to advertise. The timing of the open enrollment period would be established by the State for all carriers offering a health plan in the individual market.

A similar transitional rule would apply to carriers offering in the small employer market in certain cases. A carrier offering a health plan in the small employer market could elect not to comply with the continuous open enrollment requirement prior to January 1, 1998, with respect to employers that did not meet participation requirements of the carrier in accordance with standards established by the Secretary. A carrier electing not to comply with the continuous open enrollment requirement for these employers would be required to participate in and advertise during an annual 30-day open enrollment period, the timing of which would be established by the State for all carriers offering a health plan in the small employer market.

(e) Prohibition on pre-existing condition exclusions.—Effective January 1, 1998, a carrier offering a health plan in any sector could not exclude or limit coverage based on a pre-existing health condition of an individual.

A transitional rule would apply prior to January 1, 1998. Under the transitional rule, pre-existing condition exclusions would be limited to six months for newly insured individuals. For individuals with previous coverage, the exclusion would be reduced by one month for each month of previous coverage, if previous coverage was continuous, defined as having no more than three consecutive months without coverage. A pre-existing condition would be defined as a condition which has been diagnosed or treated during the six-month period prior to coverage. The exclusion would not apply to

services provided to newborns. A carrier that did not apply any pre-existing condition exclusion prior to enactment of this limitation would be prohibited from applying any exclusion during the transitional period.

(f) Prohibition on waiting periods.—A carrier would be required to provide coverage of an individual as of the first day of the month following the month of enrollment, except that the State would determine the effective date of enrollment of individuals enrolling in a plan during an annual open enrollment period established by a State. No additional waiting periods for coverage would be permitted.

(g) Continuation of coverage requirements.—A carrier offering a health plan in any sector would be required to guarantee renewability of coverage, and could only refuse to renew coverage due to nonpayment of premiums and to fraud or misrepresentation of a material fact. Individuals enrolled in plans for which coverage is terminated would automatically be eligible for enrollment in Medicare Part C.

Effective January 1, 1998, a carrier would be permitted to cancel or not renew a health insurance policy issued prior to the adoption of the Federal standards in a State because the policy does not provide for the guaranteed national benefit package, notwithstanding State laws or contractual requirements guaranteeing renewability of such policies. In such case, the carrier would be required to offer individuals the opportunity to convert coverage to a plan providing for the guaranteed national benefit package.

(h) Market Exit.—A carrier offering a health plan in a sector would be allowed to stop renewing and enrolling individuals and employers in the plan if the carrier is exiting the market and the carrier provides sufficient notice to enrollees and regulatory authorities. A carrier terminating such a plan would be prohibited from offering a similar plan (e.g., managed care, point-of-service, fee-for-service) for five years in the market sector in the State, or with respect to a managed care or point-of-service plan that has a service area that is smaller than the State, in the plan's service area. These market exit rules would also apply to carriers exiting the market pursuant to a joint marketing agreement entered into prior to January 1, 1994.

(i) Benefit Requirements.—A carrier offering a health plan in any sector would be required to provide the guaranteed national benefits defined in Title III as a separate package. A carrier could provide benefits under one or more of three types of health plans.

A carrier could offer a health plan (such as a fee-for-service plan) that provides for an unlimited choice of providers using the standard cost-sharing schedule set forth in Title III. Such a plan could restrict coverage for services, in accordance with limits specified by the Secretary, through utilization review, prior approval for specified services other than emergency services and not including routine prior approval for services, and exclusion of providers based on evidence of poor quality care.

A carrier could also offer a managed care plan, which provides services primarily through a provider network subject to the alternative cost-sharing schedule established for managed care plans in

Title III, and meets the additional standards required under this Title for managed care plans.

A carrier with a provider network could also choose to offer a point-of-service plan. A point-of-service plan would be defined as a plan providing for an unlimited choice of providers under which an individual enrollee could choose, at any time, to obtain services from the plan's provider network, or from any other provider. When the service is provided by a network provider, the alternative cost-sharing schedule set forth for managed care plans would apply. When the service is provided by any other provider, the standard cost-sharing schedule would apply.

A high-deductible option could be offered by a carrier in the small employer and large employer markets. In these markets, a carrier could offer the guaranteed national benefit package with a high deductible, as set forth in Title III. A high deductible plan could only be offered by a carrier to an employer that demonstrates that the employer is making contributions to a medical savings account established pursuant to Title XI.

State laws that require health plans to include benefits in addition to the guaranteed national benefit package would be preempted.

A carrier would be required to comply with requirements pertaining to the ability of eligible individuals enrolled in a private health plan to elect coverage under a State comprehensive managed mental health program as described in Title III.

(j) Community Rating Requirements.—Carriers would be required to offer health plans at a community-rated premium within each market sector in which the carrier sells coverage, except the large employer market. A community-rated premium means a premium differentiated only by enrollment category within a geographic area as defined below for each type of plan offered by a carrier (i.e., managed care, point-of-service, fee-for-service).

For purposes of community rating, the entire part of a Metropolitan Statistical Area (MSA) would be in the same community, without regard to State boundaries. In general, all non-MSA areas in a State would be in the same community, except that a State could divide non-MSA areas within the State for the purposes of community rating.

Separate community rates would apply to three enrollment categories: individual, single-parent, and family. Differences in premiums between these categories would reflect differences in the actuarial value of the guaranteed national benefit package, consistent with standards established by the Secretary.

A carrier offering a health plan in the large employer market would be required to establish separate premiums for the three enrollment categories defined above, although premiums need not be community-rated.

A carrier offering a health plan in the health alliance sector would be required to offer the plan at the same community rates that would otherwise apply to the plan if sold directly in the individual or small employer market, except that a carrier could negotiate an administrative discount with an alliance reflecting reduced enrollment and administrative costs associated with sale of the plan through the alliance. The carrier's negotiated administrative

discount would be applied uniformly to every purchaser through the alliance, except that separate discounts could be negotiated and applied to individual and small employer purchasers.

The discount would apply with respect to health alliances established by a State or local government entity under the grant program established under Subtitle E, those that would meet the requirements for health alliances under Subtitle E but are located in a State or local government area that is not participating in the grant program.

Carriers would be allowed to phase in community-rated premiums for a health plan over a three-year period. Under the phase-in schedule, the range of premiums charged by a carrier for the guaranteed national benefit package in the first year of the transition could not be greater than two-thirds of the range of premiums charged for similar benefits (for similar type of health plan such as managed care or point-of-service plan) in the previous year. The range of premiums charged for the guaranteed national benefit package in the second year of the transition could not be greater than one-half of the range of premiums charged by the carrier for a similar plan in the previous year.

(k) Study and development of risk adjustment methodology.—The Secretary would be required to develop one or more model interim risk-adjustment systems that would be issued with the Federal standards for health plans by July 1, 1995.

Each State would be required to adopt a risk-adjustment system that would apply to all carriers selling health plans in the State other than in the large employer market. The State system would be a model system developed by the Secretary, or a State's own alternative system, if approved by the Secretary.

The model system could involve risk adjustment, reinsurance, or both, and could take into account factors such as age, sex, other demographic characteristics, health status, geographic area of residence, socio-economic status, receipt of benefits under the Supplemental Security Income or Aid to Families with Dependent Children programs, and other factors that are found to predict the use of health services by individuals.

The Secretary would also be required to study and develop a separate pediatric risk adjustment or reinsurance methodology based on health risk factors existing solely within the pediatric health community.

The Secretary would be required to continue to study and periodically refine the model risk-adjustment system or systems issued.

(l) Additional standards for managed care plans and point-of-service plans.—Additional standards would be established by the Secretary for managed care plans and the provider networks of point-of-service plans. A provider network would be defined as those providers with whom the plan has entered into an agreement under which the providers are obligated to provide services covered under the health plan to individuals enrolled in the plan.

Managed care plans would be required to provide physician services primarily (i) directly through physicians who are employees or partners of such organization, or (ii) through contracts with individual physicians or groups of physicians (organized on a group practice or individual practice basis).

The provider network of a managed care plan or point-of-service plan would be required to include a sufficient number and distribution of participating providers, including primary and specialty pediatric providers for children, to ensure that network services are available and accessible to each enrollee with reasonable promptness and in a manner which assures continuity.

Health plans would be required to demonstrate that enrollees have access to specialized treatment expertise of designated centers of excellence. Plans would demonstrate that enrollees have access according to standards developed by the Secretary pertaining to plan arrangements with designated centers and to referral of patients with chronic diseases or otherwise requiring specialized services to designated centers. The Secretary would designate centers that provide specialty care, deliver care for individuals with chronic diseases or other complex cases requiring specialized treatment, and meet other requirements established by the Secretary pertaining to specialized education and training, participation in peer-reviewed research, and treatment of patients from outside the facility's geographic area. The Committee intends that, with respect to children, specialized treatment expertise would be in pediatrics.

Managed care plans would be required to ensure that medically necessary covered items and services are accessible 24 hours a day and seven days a week, and must provide for reimbursement of services provided outside the plan's provider network where medically necessary and immediately required because of an unforeseen illness, injury or condition, and if it was not reasonable to obtain the services, including trauma care services provided by designated trauma centers, through the network given the circumstances.

Carriers would be prohibited from requiring enrollees to obtain a physician referral for obstetrics and gynecology services.

Each managed care plan would be required to permit enrollees to obtain services outside the plan's provider network at the discretion of the enrollee. The Secretary, in consultation with the National Association of Insurance Commissioners, would establish an alternative cost-sharing schedule that would apply to medically necessary and appropriate out-of-network treatment and services.

In the case of a denial of in-network treatment or services or payment for out-of-network treatment or services by a managed care plan, the enrollee would have the right to an expedited appeals process, established in Title IX for such denials.

No health provider who is qualified under the terms of a health plan offered by a carrier (other than staff model and dedicated group model health maintenance organizations) and willing to accept the plan's operating terms including, but not limited to, its schedule of fees, covered expenses and quality standards, could be denied the opportunity to participate in that plan. Nothing in the Committee bill would prevent a carrier from instituting credentialing criteria, requiring fee discounts, matching the availability of health care providers to the needs of the patients enrolled in the plan, or establishing any other measure designed to maintain quality or control costs.

Standards for contracts between carriers and providers would be established with respect to provider networks. Standards would provide for public notice when applications by participating provid-

ers are to be accepted and disclosure of descriptive information regarding the plan standards for contracting with participating providers.

A carrier would be required to notify a participating provider of a decision to terminate or not renew a contract no later than 45 days before the decision would take effect, unless the failure to terminate the contract would adversely affect the health or safety of a patient. Notices would be required to include reasons for termination or non-renewal. Carriers would be required to offer providers receiving notification of termination or non-renewal an opportunity for review of the reasons, with a majority of those conducting the review to be peers of the provider that have contracts with the carrier under the managed care plan. The findings of such a review would be advisory and non-binding. Federal or State laws pertaining to the right of involved parties to appeal or seek recourse would not be superseded.

(m) Standards for marketing health plans.—A carrier offering a health plan in any sector would be required to comply with Federal standards for marketing health plans. States would be required to collect information from carriers and disseminate information on health plans sold in the State. In the case of a State without an approved regulatory program, the Secretary would assume the responsibility for collecting and disseminating the information.

A carrier would be required to file marketing materials for prior approval by the State (or, if applicable, the Secretary) and make materials available uniformly throughout the State. A carrier could not use materials to attract or limit enrollment of certain individuals or groups on the basis of personal characteristics or anticipated need for health services.

Carriers would be prohibited from paying commissions to agents or brokers based upon the actual or expected claims experience of a group or individual enrolling in a plan offered by the carrier, and could not terminate, fail to renew or limit its contract or agreement with an agent or broker for any reason related to the health status or claims experience of individuals enrolling in a health plan offered by the carrier through the agent or broker. Subject to the conditions specified, States, health alliances, or State regulatory authorities should not interfere with the ability of health insurers to contract with and pay compensation to brokers and agents.

Each State would be required to update annually and make available to consumers, in a uniform format, summary information on approved health plans sold in the State, including information on price; identity, location, qualifications and availability of participating providers; and the number of members enrolling and disenrolling from the plan; information on rights and responsibilities of enrollees, and the loss ratio of the plan. Carriers, agents, and brokers would also be required to provide this summary information to individuals and employers seeking to purchase health coverage.

The State would also make available upon request by an individual information on procedures used by an approved health plan to control utilization of services and plan expenditures and plan procedures for assuring quality of care.

Carriers would be required to provide additional information with respect to managed care plans or point-of-service plans on restrictions on payment for services provided outside the plan's provider network, and the process by which services may be obtained through the plan's provider network, coverage for out-of-area services, and a written description of any exclusions in the types of providers participating in the plan.

Carriers would be required to provide the State with any information needed by the State to prepare and disseminate the required information on each health plan sold in the State.

(n) Essential community providers.—A carrier offering a health plan in any market sector would be required to offer contracts to all essential community providers in the plan's service area. The terms of a contract offered to an essential community provider could not be less favorable than the terms offered to other providers with whom the plan has a contract, with respect to the scope of services for which payment is made.

Essential community providers would be defined as hospitals that would qualify for a Medicare disproportionate share adjustment under section 1886(d)(5)(i)(II) or 1886(d)(5)(F)(vii)(I) of the Social Security Act; Federally Qualified Health Centers as defined in section 1861(aa)(4) of the Social Security Act, except that the governance requirements need not be met with respect to membership of the Board of Directors if the facility provides assurances of significant consumer participation; family planning clinics receiving funding under Title X of the Public Health Service Act; not-for-profit diagnostic and treatment centers and clinics that provide primary care services (including obstetrics and gynecology), are located in an underserved area, and are licensed by the State under a State law in effect as of January 1, 1994; local health departments; sole community hospitals designated by the Secretary under section 1886(d)(5)(D)(iii) of the Social Security Act; rural health clinics as defined in section 1861(aa)(2) of the Social Security Act; hospitals that would qualify as Medicare-dependent hospitals under section 1886(d)(5)(G)(i) of the Social Security Act; individual providers who serve one or more areas designated by the Secretary as Medically Underserved Areas or Health Professions Shortage Areas for a total of at least 20 hours per week, or a neighborhood or community in which persons reside who are at risk of under service and the provider spends at least 20 hours per week at the principal site and is available to patients evenings and weekends at the principal site; and hospitals that the Secretary has classified as a hospital involved extensively in treatment for or research on cancer, as described in section 1886(d)(1)(B)(v) of the Social Security Act.

If an individual provider is a physician, he or she must also be board-certified, hold hospital staff privileges, or be affiliated with one or more physicians holding hospital staff privileges.

Hospitals that would qualify for a Medicare disproportionate share adjustment as specified, or would qualify as Medicare-dependent hospitals as specified, include hospitals that do not currently qualify in these categories because they are not hospitals paid under Medicare's prospective payment system. Essential community providers would also be defined to include children's hos-

pitals that would qualify for a disproportionate share adjustment as specified except that they are licensed by a State for fewer than 100 beds.

Payment by health plans to Federally Qualified Health Centers (FQHCs) and rural health clinics would be based on the reasonable cost rates applicable to such facilities under the Medicare program, unless the center or clinic chooses to contract under other payment arrangements.

(o) Utilization review standards.—The Secretary would establish standards for utilization review programs. Individuals performing utilization review could not receive financial compensation based upon the number of certification denials made by such individuals. Negative determinations about the medical necessity or appropriateness of services or the site of services would be required to be made by clinically qualified personnel and a timely review of an appeal by an enrollee or provider must be provided. Utilization review procedures would be required to be based on reasonable, current, medical evidence and applied consistently across reviewers. Carriers would be required to establish a mechanism through which providers would participate in the development of utilization review procedures. The Secretary would be required to periodically review and update utilization review program standards to reflect appropriate policies and practices in health care delivery. State laws that conflict with the Federal utilization review standards would be preempted.

Carriers would be required to provide to enrollees a written, descriptive information on the utilization review requirements of the plan.

(p) Additional requirements for insured health plans.—A carrier offering a health plan in any sector would be required to issue health cards; conform to requirements set forth in Title IX pertaining to administrative simplification, grievance procedures, quality assurance, and the enrollment verification system; and to perform other administrative functions in accordance with regulations developed by the Secretary including, where needed, the issuance of an annual written statement to enrollees verifying enrollment in a private health plan.

A carrier would be required to comply with rules established by the Secretary concerning the timing of changes in enrollment related to changes in the status of an individual (including automatic coverage of newborns and extension of coverage through the end of the month in which an individual's employment is terminated) and rules concerning the coordination of payment among health plans.

A carrier must also conform to the requirements of a State program approved pursuant to Title IV.

Effective Date.—The Federal standards would apply to carriers with respect to all health plans sold in a State on or after the date for which the Federal standards take effect in a State.

Subtitle B. Standards and requirements for self-insured health plans

Sec. 3. Restrictions on Self-Insuring

Present Law.—No provision.

Explanation of Provision.—Restrictions would be placed on entities eligible for sponsoring a self-insured health plan.

Employers with more than 100 employees would be permitted to sponsor a self-insured health plan. A multiemployer plan, as defined under ERISA, which has more than 100 active participants, or a multiemployer plan which is maintained by one or more affiliates of the same labor organization or one or more labor organizations representing the same industry, covering more than 100 employees, could self-insure.

A rural electric cooperative or rural telephone cooperative association, as defined under ERISA, which provides a group health plan with more than 100 eligible employees, could sponsor a self-insured health plan.

Multiple Employer Welfare Arrangements (MEWAs), as defined under ERISA, would be prohibited from self-insuring. MEWAs could sell health insurance, but only to the extent that they met the same standards as other carriers in each State, including financial solvency requirements.

The Committee recognizes that rural electric and rural telephone cooperatives may have an important role to play in ensuring that access to health care coverage is available in rural areas. The Committee requests the Secretary to consider ways in which these organizations may be involved in this endeavor.

Effective Date.—Effective January 1, 1998.

Sec. 4. Establishment of Federal Standards

Present Law.—Self-insured group health plans (those in which the employer assumes all or some of the risk for paying claims, instead of paying premiums to an insurance company which in turn assumes the risk) are subject to requirements under the Employee Retirement Income Security Act (ERISA). ERISA requires reporting and disclosure of certain information to the Department of Labor, and the exercise of fiduciary responsibility by the entity establishing the plan.

ERISA does not regulate the content and design of health plans provided by employers. This is up to the employer in negotiation with the employer's workforce. Moreover, under section 514 of ERISA, States are preempted from regulating employee health benefit plans. Accordingly, while plans purchased by employers from insurers must comply with State insurance laws and regulations, self-insured employers are relatively free to structure their plans, or through the collective bargaining process, if their employees are represented by a union.

Under a series of amendments to the Social Security Act, beginning with the Omnibus Budget Reconciliation Act of 1981, Medicare became secondary payer to employer health plans, in the event that an employee or other eligible beneficiary is also eligible for Medicare. For example, employers with 20 or more employees must offer Medicare-eligible employees age 65 and over, and their Medicare-eligible spouses age 65 and over, coverage under the employer's health plan, which would be the primary payer for all covered health claims. Medicare would then serve as secondary payer.

Explanation of Provision.—Federal standards for self-insured health plans, including multiemployer plans, would be established

in regulation by the Secretary no later than July 1, 1995. Plans would be certified annually by the Secretary, and any sponsor seeking certification of a plan would be required to provide information to the Secretary in a manner and format determined by the Secretary.

A person who enrolls an individual in a self-insured health plan in violation of the requirement for certification would be subject to a civil money penalty not to exceed \$25,000 for each violation. The provisions of section 1128A of the Social Security Act (other than subsection (a) and (b)) would apply. A sponsor of a self-insured health plan in violation of the requirements pertaining to non-discrimination, open enrollment, pre-existing condition exclusions, or essential community providers would be subject to a civil money penalty not to exceed \$10,000 for each violation. The provisions of section 1128A of the Social Security Act (other than subsection (a) and (b)) would apply.

Effective Date.—Self-insured plans must be certified beginning January 1, 1996.

Sec. 5. Federal Standards for Self-Insured Health Plans

Present Law.—(a) Non-discrimination requirements.—In 1978, Congress amended the Civil Rights Act to extend the prohibition against sex discrimination in employment to include discrimination on the basis of pregnancy, child birth, or related medical conditions.

Under Section 105(h) of the Internal Revenue Code, self-insured medical reimbursement plans are prohibited from discriminating in favor of highly-compensated individuals either in eligibility to participate or in benefits provided. If a self-insured firm is found to be discriminatory, amounts constituting excess reimbursements must be included in the gross income of a highly compensated employee. Insured plans are not subject to nondiscrimination requirements.

(b) Open enrollment.—No provision.

(c) Prohibition on pre-existing condition exclusions.—No provision.

(d) Prohibition on waiting periods.—No provision.

(e) Benefit requirements.—Employers with more than 25 employees are required to offer employees the option of joining qualified health maintenance organizations (HMO) as part of a health benefits plan, if so requested by a qualified HMO. Qualified HMOs are those which have applied to the Secretary and which have been found to meet the standards contained in Title XIII of the Public Health Service Act.

If more than one HMO in an area so requests, the employer is only required to offer one staff or group model HMO and one independent practice association HMO. This provision will sunset seven years after the date of the enactment of the Health Maintenance Organization Amendments of 1988, or October 24, 1995.

(f) Rating requirements.—No provision.

(g) Additional standards for managed care plans and point-of-service plans.—No provision.

(h) Essential community providers.—No provision.

(i) Utilization review standards.—No provision.

(j) Solvency standards.—No provision.

(k) Additional standards for self-insured health plans.—ERISA includes provisions relating to claims review and enforcement.

Explanation of Provision.—(a) Non-discrimination requirements.—The sponsor of a self-insured health plan could not deny coverage or vary premium contributions charged to any eligible individual due to health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability or medical condition.

The sponsor of a self-insured plan would be prohibited from engaging directly or indirectly in activities, including the selection of a service area or selection of a provider network, that would have the effect of discriminating against an individual on the basis of race, national origin, religion, gender, sexual orientation, language, socio-economic status, age, health status or anticipated need for health services.

(b) Open enrollment.—The sponsor of a self-insured plan would be required to provide for an annual open enrollment period of no less than 45 days during which an employee could switch among alternative plans offered by the sponsor. During the first year of enrollment under the self-insured plan, employees could switch among health plans offered by the sponsor outside of the open enrollment period. The employee would be required to give 45-days notice before the effective date of the change in health plans and the employee could make such a change only once within the year. After the first year of enrollment, changes could only be made during the sponsor's open enrollment period.

The sponsor of a self-insured plan could not refuse to enroll any newly-eligible individual at any time.

(c) Prohibition on pre-existing condition exclusions.—The sponsor of a self-insured health plan could not exclude or condition coverage of eligible individuals based on a pre-existing health condition.

(d) Prohibition on waiting periods.—The sponsor of a self-insured health plan would be required to provide coverage of an individual as of the first day of a given month, except that the sponsor would determine the effective date of enrollment of individuals enrolling in a plan during an annual open enrollment period established by a State. No additional waiting periods for coverage would be permitted.

No additional waiting periods for coverage would be permitted.

(e) Benefit requirements.—The sponsor of a self-insured health plan would be required to provide the guaranteed national benefit package as a separate package. Additional benefits could be offered.

The sponsor of a self-insured plan that is not an employer would be required to meet non-discrimination standards with respect to providing benefits in excess of the guaranteed national benefit package similar to the standards established for employers under Title II.

The sponsor of a self-insured health plan would be required to make available to employees the choice of a managed care plan, if available, and a plan that provides an unlimited choice of providers. The requirement for unlimited choice of providers could be met through a point-of-service plan, under which the cost-sharing re-

quirements for services provided outside of the plan's provider network could not exceed the cost-sharing requirements provided under the guaranteed national benefit package.

The sponsor of a self-insured plan would not be permitted to offer a self-insured high deductible plan. Employers that generally sponsor a self-insured plan for their employees could provide their employees the option of enrolling in a high deductible plan that is purchased from a carrier. In that case, the employer could only offer a high-deductible plan in conjunction with a medical savings account pursuant to Title XI.

The sponsor of a self-insured plan would be required to make available to eligible individuals, summary information on each plan offered, including information on price, participating providers, and the rights and responsibilities of enrollees, and would be required to disclose information on the utilization review program used by the plan.

The sponsor would be required to comply with requirements pertaining to the ability of eligible individuals enrolled in a private health plan to elect coverage under a State comprehensive managed mental health program as described in Title III.

(f) Rating requirements.—The sponsor of a self-insured plan which requires employee contributions (i.e., the employer contributes less than 100 percent of the cost of the plan) must establish separate premium contributions for three enrollment categories: individual, single parent, and family. Differences in premiums among the three enrollment categories could differ only in relation to the difference in the actuarial value of benefits between the enrollment categories.

The sponsor of a self-insured plan could choose to vary premiums by geographic area, but only if the geographic areas are defined using the definitions of community established under the community rating requirements for insured health plans under Subtitle A.

(g) Additional standards for managed care plans and point-of-service plans.—A managed care plan offered by the sponsor of a self-insured health plan would be required to meet Federal standards applicable to managed care plans that are insured health plans under Subtitle A.

(h) Essential community providers.—The sponsor of a self-insured health plan would be required to offer contracts to essential community providers under the same standards and requirements that apply to insured health plans under Subtitle A.

(i) Utilization review standards.—The sponsor of a self-insured health plan would be required to meet the utilization review standards established by the Secretary for insured health plans under Subtitle A.

(j) Solvency standards.—The sponsor of a self-insured health plan would be required to meet solvency standards established by the Secretary for such plans, which could include requirements regarding the purchase of stop-loss coverage. An individual enrolled in a self-insured health plan that becomes insolvent would not be liable for any payment for services beyond any cost-sharing requirements.

(k) Additional standards for self-insured health plans.—The sponsor of a self-insured health plan would be required to issue

health cards, comply with requirements set forth in Title IX pertaining to administrative simplification, grievance procedures, quality assurance, and the enrollment verification system, and to perform other administrative functions in accordance with regulations developed by the Secretary including, where needed, the issuance of an annual written statement to enrollees verifying enrollment in a private health plan.

The sponsor of a self-insured health plan would be required to comply with rules established by the Secretary concerning the timing of changes in enrollment related to changes in the status of an individual (including automatic coverage of newborns and extension of coverage through the end of the month in which an individual's employment is terminated) and rules concerning the coordination of payment among health plans.

The sponsor must also conform to the applicable requirements of a State program approved pursuant to Title IV, which includes an exception with respect to certain multistate employers and multi-employer plans.

Effective Date.—January 1, 1996.

Subtitle C. Standards and requirements for supplemental health benefit plans

Sec. 6. Standards for Plans that Supplement the Guaranteed National Benefit Package

Present Law.—Health plans that supplement private health benefits purchased by employers and individuals are not subject to Federal standards. Section 1882 of the Social Security Act establishes standards for Medicare supplemental insurance policies, known as Medigap policies. These policies must be certified as meeting Federal standards.

(a) Requirement for certification.—Medicare supplemental insurance policies must be certified as meeting Federal standards. A policy issued in a State with an approved regulatory program approved by the Secretary is deemed to meet Federal standards.

(b) Standardized benefits.—Federal standards for Medicare supplemental insurance policies include a requirement that policies provide for standardized benefits. OBRA '90 required the definition of up to ten standardized benefit packages.

(c) Non-duplication of benefits.—Federal standards for Medicare supplemental insurance policies prohibit the sale of a Medicare supplemental policy to an individual already covered under such a policy. Insurers are required to obtain written information from applicants regarding existing health insurance coverage.

(d) Open enrollment.—Medical underwriting and certain other practices are prohibited with respect to Medicare supplemental insurance policies for which an individual age 65 or older applies during the six-month period beginning with the first month during which the individual is first enrolled for benefits under Medicare Part B.

(e) Non-discrimination requirements.—Federal standards for Medicare supplemental insurance policies prohibit the issuer of a policy from denying or conditioning the issuance or effectiveness of the policy or discriminating in the pricing of the policy because of

health status, claims experience, receipt of health care or medical condition with respect to an application for coverage submitted during the six-month period beginning with the first month when an individual who is age 65 or older first becomes eligible for Medicare part B benefits.

(f) Continuation of coverage.—Federal standards for Medicare supplemental insurance policies require policies to be guaranteed renewable and coverage cannot be canceled or not renewed for any reason other than nonpayment of premiums or material misrepresentation.

(g) Community rating requirements.—No provision.

(h) Marketing requirements.—Federal standards for Medicare supplemental insurance policies require that advertisements must be provided to the State Insurance Commissioner for review and approval to the extent required under State law. In addition, uniform language, definitions and format must be used in describing benefits available under the policy.

Explanation of Provision.—(a) Requirement for certification.—A carrier offering a health insurance policy to individuals and employers that supplements the benefits provided under the guaranteed national benefit package would be required to meet Federal standards defined by the Secretary, subject to the civil monetary penalties imposed on plans that do not meet Federal standards.

The Secretary would issue the Federal standards for plans that supplement the guaranteed national benefit package by July 1, 1995. Supplemental benefits provided by self-insured health plans, including multiemployer plans, would not be subject to this requirement, provided such plans meet the requirements for certification as self-insured health plans.

Policies subject to the standards for supplemental benefit plans would be defined to exclude coverage only for accident, disability income, or long-term care insurance, or any combination thereof; Medicare supplemental insurance; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; worker's compensation or similar insurance; automobile medical-payment insurance; coverage for a specified disease or illness; a hospital or fixed indemnity policy; and coverage provided exclusively to individuals who are not eligible individuals under the Health Security Act.

A person who sells or issues a supplemental benefit plan in violation of the requirement for certification would be subject to a civil money penalty not to exceed \$25,000 for each violation. The provisions of section 1128A of the Social Security Act (other than subsection (a) and (b)) would apply. A person that sells or issues a supplemental benefit plan in violation of the requirements pertaining to non-discrimination, open enrollment, non-duplication, continuation of coverage, or marketing would be subject to a civil money penalty not to exceed \$10,000 for each violation. The provisions of section 1128A of the Social Security Act (other than subsection (a) and (b)) would apply.

(b) Standardized benefits.—Supplemental benefits sold to employers and individuals would be restricted to those provided in up to ten standardized supplemental benefit packages defined by the Secretary. In defining supplemental benefit packages, the Secretary

would be directed to take into account current State laws that mandate the inclusion of particular benefits and providers of service, and other benefits typically offered by private insurance under present law. Medicare definitions of providers need not apply with respect to services included in the supplemental benefit packages.

At least one of the benefit packages would be designed to supplement benefits provided by managed care plans under the alternative cost sharing schedule designed for such plans.

The standardized benefit packages for plans that supplement the guaranteed national benefit package would be defined separately from the Medicare supplemental insurance, benefit packages established under section 1882 of the Social Security Act.

(c) Non-duplication of benefits.—The sale of an insurance plan that duplicates benefits included in the guaranteed national benefit package or included in one or more of the standardized supplemental benefit packages would be prohibited.

The sale of an insurance plan that duplicates benefits included in the guaranteed national benefit package or included in one or more of the standardized supplemental benefit packages would be prohibited. Long-term care insurance, accident-only insurance, disability income insurance, hospital or fixed indemnity insurance, insurance that limits coverage to specific diseases or conditions, coverage as a supplement to liability insurance, workers compensation or similar insurance, automobile insurance, liability insurance (including general liability insurance and automobile insurance), and insurance sold exclusively to individuals that are not required to be covered under the guaranteed national benefit package would not be considered to duplicate benefits if the plan always pays benefits regardless of other coverage.

The Committee intends that nothing in these requirements would prohibit colleges and universities from providing primary and preventive health care services to students enrolled at the institution, and further intends that any fee charged by the college or university for such services would not be considered supplemental insurance for the purposes of this section, and would not be considered to duplicate benefits to which an individual is otherwise entitled under this Act.

The sale of a supplemental benefit plan to an individual already enrolled in a supplemental benefit plan would be prohibited unless the new policy would replace an existing supplemental plan.

(d) Open enrollment.—A carrier offering a supplemental benefit plan must provide for an annual open enrollment period of at least 30 days during which the carrier could not deny coverage to any employer or individual due to health status, claims experience, receipt of health care, medical history, lack of evidence of insurability or medical condition, or for any other reason.

A supplemental benefit plan sold to an individual during the open enrollment period could not exclude coverage for a pre-existing condition. A supplemental benefit plan sold to an individual at any other time could provide for a pre-existing condition exclusion of up to six months. A pre-existing condition would be defined as a condition which has been diagnosed or treated during the six-month period prior to coverage.

(e) Non-discrimination requirements.—A carrier offering a supplemental benefit plan would be prohibited from engaging directly or indirectly in activities, including the selection of a service area or selection of a provider network, that would have the effect of discriminating against an individual on the basis of race, national origin, religion, gender, sexual orientation, language, socio-economic status, age, health status or anticipated need for health services.

(f) Continuation of coverage requirements.—A carrier offering a supplemental benefit plan would be required to guarantee renewability of coverage, and could only refuse to renew coverage due to nonpayment of premiums and to fraud or misrepresentation of a material fact.

(g) Community rating requirements.—A carrier offering a supplemental benefit plan would be required to offer coverage at community-rated premiums, using the same enrollment categories and geographic areas as would apply to the sale of health plans provided under Subtitle A.

(h) Marketing requirements.—The sale of a supplemental benefit plan could not be tied to the purchase of the guaranteed national benefit package or any other policy. An exception would be provided with respect to managed care plans, under which a carrier that provides a managed care plan could offer a policy that supplements the guaranteed national benefit package exclusively to individuals enrolled in the managed care plan. Such a supplemental plan would be one of the standardized plans designed by the Secretary to supplement benefits provided under a managed care plan. A carrier offering a managed care plan and providing such a supplemental benefit plan would not be prohibited from otherwise participating in the market for supplemental benefit plans by selling other standardized supplemental plans.

Marketing materials for supplemental benefit plans would be approved in advance, be made available uniformly throughout the State, and could not be used to attract or limit enrollment of certain individuals or employers.

Effective Date.—In general, States would be required to adopt the Federal standards effective for supplemental benefit plans sold to employers and individuals beginning on January 1, 1997. States in which the legislature was not scheduled to meet during calendar year 1996 would be required to adopt the standards effective for supplemental benefit plans sold to individuals and employers beginning on January 1, 1998 or the first day of the first quarter after the close of the next scheduled meeting of the State legislature, whichever is earlier.

Sec. 7. Medicare Supplemental Insurance Policy Amendments

Present Law.—(a) Standardized benefits.—In order to be certified by the Secretary, benefits provided in a Medicare supplemental insurance policy must conform to one of ten standardized benefit packages.

(b) Open enrollment.—Medical underwriting and certain other practices are prohibited with respect to Medicare supplemental insurance policies for which an individual age 65 or older applies during the six-month period beginning with the first month during

which the individual is first enrolled for benefits under Medicare Part B.

Explanation of Provision.—(a) Standardized benefits.—The Secretary would be required to modify the existing standardized benefit packages for Medicare supplemental insurance plans to conform to changes in benefits provided in this Act under Medicare Parts A and B. The Secretary would publish the modified benefit packages by July 1, 1995.

(b) Open enrollment.—The intent of the current law provision would be clarified that in the case of individuals enrolled in part B prior to age 65, Medigap insurers are required to offer coverage, regardless of medical history, for a six-month period when the individual reaches age 65 and that insurers are prohibited from discriminating in the price of policies for such an individual, based upon the medical or health status of the policyholder.

In addition to the six-month open enrollment period provided under current law, each carrier offering a Medicare supplemental insurance plan would be required to participate annually in a 30-day open enrollment period, the timing of which could be coordinated for all carriers by the Secretary. During the 30-day open enrollment period, a carrier offering a Medicare supplemental insurance policy could not deny coverage to a Medicare beneficiary due to health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability or medical condition.

A Medigap policy sold to an individual during the six-month open enrollment period could not exclude coverage for a pre-existing condition. A policy sold to an individual at any other time could provide for a pre-existing condition exclusion of up to six months. A pre-existing condition would be defined as a condition which has been diagnosed or treated during the six-month period prior to coverage.

The Secretary would issue Federal standards pertaining to this requirement in regulation no later than July 1, 1995.

Effective Date.—States would be required to adopt the modified benefit packages under subsection (a) effective for Medigap policies sold or issued in the State beginning on January 1, 1998. The clarification of present law provided in subsection (b) would be effective on January 1, 1995 and would apply to individuals turning age 65 on or after the effective date of section 1882(s)(2) of the Social Security Act. Individuals who attained age 65 after that date and prior to January 1, 1995 would be provided a 6-month open enrollment period beginning on January 1, 1995.

States would be required to adopt the Federal standards for annual open enrollment under subsection (b) effective for Medigap policies sold or issued in the State beginning on January 1, 1997. States in which the legislature was not scheduled to meet during calendar year 1996 would be required to adopt the open enrollment requirement effective for Medigap policies sold or issued in the State beginning on January 1, 1998 or the first day of the first quarter after the close of the next scheduled meeting of the State legislature, whichever is earlier.

Subtitle D. Transitional insurance reforms

Sec. 8. Transitional Insurance Reforms

Present Law.—(a) Establishment of transitional insurance standards.—No provision.

(b) Continuation of coverage.—No provision.

(c) Limits on pre-existing condition exclusions.—No provision.

(d) Rating requirements.—No provision.

(e) Limitation on variation in premium increases.—No provision.

(f) More Stringent State laws not preempted.—Some States have established standards for health insurance sold to small employers.

(g) Limit on changes in self-insured health plans.—No provision.

Explanation of Provision.—(a) Establishment of transitional insurance standards.—The Secretary would issue transitional insurance reform standards, and would be authorized to issue interim final regulations to carry out this requirement. The Secretary could consult with the States and the National Association of Insurance Commissioners in developing the standards.

The transitional insurance reform requirements would be construed in a manner that assures, to the greatest extent practicable, continuity of benefits under health plans in effect on the date of enactment of this Act.

Carriers and sponsors of self-insured health plans would be required to file a certification with the Secretary or the State indicating that they are in compliance with the transitional insurance reform requirements.

Requirements would be enforced by the Secretary, subject to a civil monetary penalty up to \$25,000 for each violation. The provisions of section 1128A of the Social Security Act (other than subsection (a) and (b)) would apply. The Secretary could elect to enter into agreements with States to enforce the transitional requirements. A civil action could be brought by the Secretary to enjoin any act or practice which violates the transitional insurance reform requirements, or to obtain other appropriate equitable relief to redress such violations or to enforce any provision including, in the case of a wrongful termination of coverage or failure to renew coverage, the reinstatement of coverage effective as of the date of the violation.

(b) Continuation of coverage.—A carrier and a sponsor of a self-insured health plan would be required to maintain coverage in force and to accept new members in a group plan without respect to health status.

An exception would be provided with respect to a carrier that is transferring a health plan to another carrier pursuant to a joint marketing agreement entered into prior to January 1, 1994.

The Secretary would establish standards with respect to the application of transitional insurance reform requirements in the case of other situations in which health plans are transferred from one carrier to another through assumption, acquisition or other means.

(c) Limits on pre-existing condition exclusions.—Pre-existing condition exclusions would be limited to six months for newly insured individuals. For individuals with previous coverage, the exclusion would be reduced by one month for each month of previous coverage, if previous coverage was continuous, defined as having no

more than three consecutive months without coverage. A pre-existing condition would be defined as a condition which has been diagnosed or treated during the six-month period prior to coverage. The exclusion would not apply to services provided to newborns. This requirement would apply both to health plans sold to individuals and employers and to self-insured health plans. Health plans that did not apply any pre-existing condition exclusion prior to enactment of this limitation would be prohibited from applying any exclusion.

(d) Rating requirements.—Carriers selling health plans to employers or individuals would be required to apply consistent rating practices with respect to demographic characteristics and changes in benefit design across all covered individuals or groups. Rating practices could differ between plans sold to individuals, plans sold to employer groups with fewer than 100 employees, and plans sold to other employer groups.

(e) Premium increases.—Premium increases for health plans sold to individuals and for health plans sold to employers with fewer than 100 employees could not vary based on claims experience. Premiums could change as a result of change in the number of individuals covered under the plan, changes in the group or individual characteristics such as age, gender, family composition or geographic area, changes in benefits or other material terms and conditions of the plan, but not for reasons related to health status, claims experience or duration of coverage under the plan. Changes in premiums due to demographic characteristics or benefit design must be in conformance with standards for consistent application of rating practices. Other than for the factors specified, changes in premiums must be the same for all individuals with respect to plans enrolling individuals and for all groups, with respect to group plans.

(f) More stringent State laws not preempted.—The transitional insurance reform requirements would not preempt any existing State insurance reform law with respect to health plans sold to individuals and employers that is more stringent.

(g) Limit on changes in self-insured health plans.—The sponsor of a self-insured health plan would be prohibited from reducing or limiting coverage with respect to any medical condition for which the cost of treatment is expected to exceed \$5,000 a year.

Effective Date.—Except as provided below, the transitional insurance reforms established under this subtitle would be effective for health plans sold, issued, or renewed in a State beginning January 1, 1995 and until the State adopts the Federal insurance reform standards established under this Title which are required to be issued by the Secretary by July 1, 1995. Subsection (b) requiring continuation of coverage would be effective upon the date of enactment. Subsection (g) would be effective upon the date of enactment and would terminate on January 1, 1996.

Subtitle E. Health alliances

Sec. 9. Grants for Health Alliances

Present Law.—No provision.

Explanation of Provision.—A Federal grant program would be established to assist States and qualified local governments in the planning, development, and initial operation of regional health alliances. Individual grants would be awarded for a period of up to five years and the total amount of assistance could not exceed \$5 million. \$150 million would be authorized for the five-year period beginning with fiscal year 1995.

In order to be eligible for a Federal grant, a State would be required to meet requirements established by the Secretary of HHS. Local governments (including municipal and county governments) qualified to receive a grant would be limited to those within a Metropolitan Statistical Area with a population of at least one million.

Nothing would preclude a State or local government from establishing health alliances without participating in the Federal grant program, and in such cases nothing would require that a health alliance be established under the same arrangements and conditions as required under the Federal grant program.

States participating in the grant program could establish multiple regional health alliances, but alliances could not overlap, and an alliance must be available everywhere in the State. One or more contiguous States could jointly establish an interstate regional health alliance.

In establishing alliances, States or local governments could not subdivide a Metropolitan Statistical Area (MSA). In establishing alliance boundaries, a State could not discriminate on the basis of or otherwise take into account race, age, gender, sexual orientation, language, religion, national origin, socio-economic status, or perceived health status.

A regional health alliance could be operated by a State agency, a local government entity, or under contract with a non-profit organization. The alliance would be required to be governed by a Board of Directors, who represent employers and consumers in equal numbers. The governing board could not include providers or representatives of health plans. The Board would be required to reflect the racial and ethnic composition of the region served by the alliance.

Regional health alliances would have to meet standards established by the Secretary pertaining to the management of finances, maintenance of records, accounting practices, auditing procedures and financial reporting.

Regional health alliances participating in the Federal grant program would be required to enter into an agreement with any health plan meeting Federal standards in the alliance area that seeks an agreement to offer health insurance through the regional alliance.

Health plans offered through the regional alliance would be sold at the same community rates as health plans sold directly to individuals or employers. Health plans offering coverage through a health alliance could provide a discount for enrollment and administrative costs. The administrative discount would be required to be specified by the health plan in advance in accordance with standards established by the Secretary and would have to be applied uniformly across alliances with which the health plan had agreements.

Alliances would offer to enter into agreements to provide services to any employer in the alliance area with fewer than 100 employees. Within one year after its establishment, a regional health alliance would be required to seek out and inform all eligible employers in the alliance area of the services available through the alliance.

Under the agreement with employers, the regional health alliance would provide a number of services. Alliances would provide information in a uniform format to each employee of participating employers regarding health benefits available from each health plan with which the health alliance has an agreement, as well as Medicare Part C. Information provided on participating plans would include price; identity, location, qualifications and availability of participating providers; and number of members enrolling and disenrolling from the plan.

Regional health alliances would enroll employees of participating employers into the health plan of their choice, and would receive and forward premiums from employers and employees to the health plan.

Alliances would also coordinate with other health alliances in order to provide health benefits to employees who reside in the alliance area but whose employer's place of business is outside of the area. Such services would be provided in coordination with the health alliance for the area in which the principal place of business of the employer is located.

States could allow regional health alliances to charge a fee to employers of up to two percent of premium in exchange for the services provided in accordance with standards established by the Secretary.

Regional health alliances would make similar services available to individuals and families that are not employees of participating employers but who reside in the alliance area.

Health alliances would conduct an annual open enrollment period on behalf of the participating employers. The health alliances would maintain a grievance hot line, and would investigate each problem with a health plan brought to its attention.

States participating in the grant program could provide that alliances would be the exclusive vendor of health plans in the State, but such application would be governed by the rules for State programs established under Title IV.

States participating in the grant program could, at the option of the State, designate regional health alliances as agencies to enforce a State capital allocation plan for the review and approval of capital expenditures in a State. Under this option, any capital expenditures in a State exceeding \$1 million would be subject to review, and States could establish a lower threshold. Capital expenditures for a project which, in the aggregate, exceed \$1 million or the alternative State threshold amount would be subject to review, even if individual component expenditures did not exceed the threshold.

A State using the regional health alliance for the purposes of enforcing a capital allocation plan would be required to have a capital allocation plan that is designed to assure that the needs of the States residents for health care services are met. The plan would be required to be consistent with criteria developed by the Sec-

retary, including occupancy targets for hospital facilities and utilization targets for inpatient and outpatient health care services and equipment. An opportunity for formal review and comment would be required to be provided before the plan could become final.

The capital allocation plan would be required to provide for regionalization of services where appropriate, and to identify which facilities (or parts of facilities) would be closed in order to reach occupancy and utilization targets for health facilities and services. The plan would address the special needs and circumstances of public and other disproportionate share hospitals and the provision of trauma care.

The plan would provide, in a manner satisfactory to the Secretary, for such controls as are necessary to ensure that the capital expenditures approved under the capital allocation plan would not result in facility and service capacities in excess of the needs of the population to be served.

A review of capital expenditures by the regional health alliance would be required to include consideration of a number of factors, including the relationship of a proposed activity to the State's capital allocation plan, the extent to which quality of care would be impacted at the facility under review and at other existing facilities, the availability of alternative, less costly, or more effective means of providing the services, the impact of the project on the utilization of the applicants capital resources, the need to eliminate unnecessary duplication of services, the impact on the price of health care services to the population to be served, and the extent to which the proposed facilities and services will be available to all residents of the area.

A capital allocation plan need not provide for review of health facilities and services provided in rural areas if the State has developed a rural health plan according to criteria established by the Secretary under the Essential Access Community Hospital program.

Review of capital expenditure applications by the regional health alliance would be required to be made in public in accordance with procedures and criteria established by the Secretary. If a determination is made by the review agency that there is a need for a proposed activity, other health care providers (in addition to the original applicant) would be allowed to file an application to address the identified need, and the review agency would select the applicant that was determined to best meet the needs of the community. States would be required to create a schedule for the review of applications. To the extent possible, applications affecting substantially the same service area would be considered at the same time.

The State's capital allocation plan would provide for on-going review by the regional health alliance of approved activities and provide for the ability of the State to rescind the approval of the terms of the agreement if they are not upheld.

In the case of a State participating in the regional health alliance grant program that chooses to designate the regional health alliance as the agency to enforce the State's capital allocation plan, the Secretary would be directed to enter into agreements pursuant to Section 1122 of the Social Security Act with the State providing for

denial of Medicare capital payments for capital expenditures not approved under the State plan.

Title VI. Stand-by Cost Containment in the Private Sector

Subtitle A. National health expenditure estimates

Sec. 1. Development of the National Expenditure Estimates.

Present Law.—(a) Establishment of estimate.—No provision.

(b) Estimate for 1995—the base year.—No provision.

(c) Publication of estimates.—No provision.

(d) Limits on growth in 1996 and subsequent years.—No provision.

(e) Adjustments for universal coverage and additional benefits.—No provision.

Explanation of Provision.—(a) Establishment of Estimate.—The Secretary of HHS would develop a national private sector per capita health expenditure estimate of total spending for health services for each year, beginning with 1996. A Medicare per capita health spending estimate would be developed under Subtitle C of Title VIII of this Act.

The private per capita estimate would include all payments (including cost-sharing) made for the services covered under the national guaranteed benefit package and under the low-income supplemental plans, including: inpatient and outpatient hospital services; physician services; diagnostic testing services (including laboratory and x-ray services); prescription drugs; home health, durable medical equipment, orthotics and prosthetics; mental health services (including inpatient and outpatient drug and alcohol treatment); rehabilitation services; and expenditures for services provided in managed care plans.

The estimate would exclude: (1) payments for non-prescription medications, (2) payments for inpatient mental health services of a custodial nature, (3) payments for personal comfort or convenience items, (4) payments for homemaker, home health aide, and personal care services, (5) payments made by certain Federal government programs, including Medicare, Medicaid, CHAMPUS, health care programs within the Department of Veterans Affairs, and the costs of services provided to health care facilities and providers of the Department of Defense, and (6) payments made by workers' compensation, automobile, or other liability insurance programs.

(b) Estimate for 1995—the base year.—The Secretary would compute a baseline private per capita estimate for 1995, based on the most recent actual data available (1993), inflated forward to 1995 using the Secretary's estimate of the baseline rate of growth in expenditures included within the estimate.

In general, the Secretary would not be permitted to adjust the private per capita estimate, baseline growth rates or other factors once the initial estimates were established. The Secretary could recommend changes in the estimate, but implementation of such changes would require Congressional action.

The Secretary would be permitted to make certain specified adjustments in the private per capita estimate for 1995. Specifically,

the estimate for 1995 could be amended by the Secretary to correct errors in the estimation of spending in 1993 and errors in the estimation of the growth in spending between 1993 and 1995, relative to the predicted level. In the case where the Secretary makes an adjustment under this provision, the Secretary would also make conforming changes to the estimates for subsequent years.

(c) Publication of estimates.—Beginning in 1995, the Secretary's initial determination of the private per capita estimates for the following year would be published in the Federal Register by April 1 of each year. The Secretary's final determination of the estimate would be published by October 1 of each year for the following year. In the initial year, the Secretary would also determine and publish the baseline rate of growth in the private per capita estimate.

(d) Limits on growth in 1996 and subsequent years.—In general, the private per capita health expenditure estimate would be equal to the private per capita estimate for the preceding year, increased by the sum of one plus the five-year moving average of the annual percentage rate of growth in the per capita gross domestic product (GDP) plus an adjustment factor.

The adjustment factor would be set by statute such that the estimated, baseline rate of growth in the private sector per capita health spending would be reduced by two percentage points in 1996. The factor would be further reduced by one additional percentage point each subsequent year, but would not be reduced to less than zero. The adjustment factor could be changed by subsequent legislation in order to accommodate an unanticipated need for additional health spending.

(e) Adjustments for universal coverage and additional benefits.—For the year that universal coverage and coverage under Medicare Part C become effective (1998), the private per capita estimate would be adjusted to reflect the impact of universal coverage. Specifically, the estimate would be reduced to remove from the private per capita estimate the amount of current spending related to uncompensated care and to the shortfall in payments under the current Medicaid program. The estimate also would be adjusted to reflect any net change in spending due to the implementation of universal coverage and the introduction of the Medicare drug benefit. In establishing the estimate for the year 2003, the Secretary would adjust the estimate to reflect the addition of the cap on out-of-pocket expenditures as provided under title III of this Act.

Effective Date.—Effective upon the date of enactment.

Sec. 2. Classes of Health Care Services

Present Law.—(a) Definitions of classes.—No provision.

(b) Recommendations by commissions.—The Prospective Payment Assessment Commission (ProPAC) and the Physician Payment Review Commission (PPRC) are independent commissions that provide annual recommendations to the Congress on issues relating to hospital and physician payments under Medicare, and to issues relating to health care services and financing generally.

Explanation of Provision.—(a) Definitions of classes.—The services covered under the guaranteed national benefit package or under the low-income supplemental benefits package would be

grouped into separate, non-overlapping "classes" of services. The classes would initially be specified: (i) inpatient hospital services (other than mental health services); (ii) outpatient hospital and ambulatory facility services (including renal dialysis and excluding mental health services in such facilities); (iii) diagnostic testing services (including clinical laboratory and x-ray services); (iv) physician and other professional medical services (other than mental health services); (v) home health services; (vi) prescription drugs, biologicals and insulin; (vii) nursing facility services covered under the nationally guaranteed benefit package and the low-income supplemental benefits; (viii) rehabilitation services including physical, occupational, and speech therapy; (ix) durable medical equipment and supplies; and (x) mental health services. Services which fall into more than one category are included in the first class in the above list to which they could be classified.

The Secretary could group other items and services into a new class or classes, or a specified class or classes, as may be appropriate.

Items and services excluded from the determination of the private per capita estimate would also be excluded in the definition of the classes of services.

The Secretary would publish a proposed specification of the classes by April 1, 1995, and final specifications by October 1, 1995. The Secretary would include in such publications the definition of the class or classes to be established, the services within each class, and the methods and sources of data for computing the national private per capita estimate for each class.

Once established, the Secretary would not be permitted to modify or change the classes. The Secretary would periodically submit a report to Congress recommending changes in the classes.

(b) Recommendations by commissions.—The Prospective Payment Assessment Commission (ProPAC), the Physician Payment Review Commission (PPRC), and the Prescription Drug Payment Review Commission (DrugPRC) established under title III would submit recommendations to the Congress on the initial specification of the classes not later than June 1, 1995.

Each Commission also would make periodic reports to the Congress on changes in the system of classification.

Effective Date.—Effective upon the date of enactment.

Sec. 3. Allocation of the Health Expenditure Estimate by Class of Service

Present Law.—(a) Allocations by class of service.—No provision.

(b) Recommendations by commissions.—ProPAC and PPRC are independent commissions that provide annual recommendations to the Congress on issues relating to hospital and physician payments under Medicare, and to issues relating to health care services and financing.

Explanation of Provision.—(a) Allocations by class of service.—In general, the national private per capita health expenditure estimate would be allocated annually to each class of health services.

The amount allocated to each class, for a year, would be equal to the national private per capita estimate for the class for the preceding year, increased by the annual private sector trend factor for

the class. The sum of the allocations so determined for all classes would be uniformly adjusted such that the sum across all classes would be equal to the private per capita estimate for the year.

The Secretary would, in conjunction with the publication of the national private per capita estimate, publish the allocation of the private per capita estimate to each class. The initial allocations for 1996 would be published not later than August 1, 1995.

In order to determine the initial allocation of the private per capita estimate by class of service, the Secretary would determine a base level of per capita spending within each class, using data based on 1993. In addition, the Secretary would estimate the annual per capita rate of growth of spending for each class during the five-year period ending in 1995. The base allocation of the classes in 1995 would be estimated by increasing the allocations to each class in 1993 to 1995 by the trend factor, and then making a uniform adjustment in the allocation to each class such that the sum across all classes would be equal to the national private per capita estimate in 1995.

The Secretary could not subsequently change the allocations. If the Secretary determined that a change in the allocation of the estimate among classes were appropriate, the Secretary would submit a recommendation to the Congress regarding such a change. Such recommendation would include an explanation of the rationale for such change, and the impact on the allocation of the national private per capita estimate resulting from such proposed change.

The Secretary would be permitted to make certain specified adjustments in the allocations for 1995, and to the trend factors. Specifically, the estimate for 1995 could be amended by the Secretary to correct errors in the estimation of the allocation of spending in 1993, and errors in the estimation of the growth in per capita spending in each class for the five-year period ending in 1995. In the case where the Secretary makes an adjustment under this provision (or changes the private per capita estimate for 1995), the Secretary also would make conforming changes to the allocations to the classes for years after 1995.

The Secretary would adjust the allocation of the 1998 national private per capita estimate to reflect universal coverage, implementation of Medicare Part C and the Medicare drug benefit. Specifically, the allocations would be adjusted in a manner consistent with the 1998 adjustments to the national private per capita spending estimate to remove from the private per capita estimate the amount of current spending related to uncompensated care and to the shortfall in payments under the current Medicaid program. The allocation also would be adjusted to reflect any net change in private per capita spending due to the implementation of universal coverage.

(b) Recommendations by commissions.—ProPAC, PPRC, and DrugPRC would review and report to the Congress annually on the allocation of health expenditures to the different classes of health services. The Commissions would review the effect of the trend factors used in the allocation of the estimate among classes of services and make recommendations about adjustments in the trend factors to take into account: changes in health care technology; changes in

the pattern and practices relating to health care delivery found to be appropriate; changes in the distribution of health care services; and the special health care needs of under-served rural and inner-city populations.

Each Commission would make periodic reports to the Congress on changes in the system of classification, and include in these reports such recommendations as the Commissions deem appropriate.

Effective Date.—Effective upon the date of enactment.

Sec. 4. Monitoring of Health Spending

Present Law.—The Medicare Cost Report (MCR) has been used since the inception of the Medicare program. Its main purpose is to determine the reimbursable cost of hospital-provided services, and to determine Medicare's share of these costs. After implementation of the prospective payment system for hospitals, its main focus has shifted to determining Medicare cost-based payments for hospital outpatient services and the direct costs of graduate medical education. Over 90 percent of all acute care hospitals submit their cost reports electronically.

Explanation of Provision.—All providers who submit claims to either the public plans or to private payers would be required to submit uniform annual reports to the Secretary of HHS to be used in monitoring and enforcing compliance with the national health spending estimates.

The Secretary would establish the requirements for such reports. The Secretary also would provide for a method by which these reports could be submitted electronically. In developing the requirements for these reports, the Secretary would, to the extent practicable, base the requirements on existing reports that are provided under both the Medicare and Medicaid programs, including the Uniform Hospital Cost Reporting demonstration project.

Hospitals and other facilities and institutions would provide cost and revenue data; other providers would submit only revenue data. The reports would include information on all revenues received during the preceding calendar year relating to medical services provided to all patients, broken down separately by class of service and type of payer (Medicare A, B and C, Medicaid, CHAMPUS, private insurance plans, and direct patient out-of-pocket costs).

Reports would be submitted by April 15 of each year, and would include data with respect to the preceding calendar year. The initial report, covering payments made for services provided in 1996, would be due on April 15, 1997. Information collected under this system would not be disclosed in a manner that would permit the identification of individual providers of services.

Revenues for activities not related to the provision of direct patient care, such as teaching or research, or for services that are explicitly excluded from the system of national health expenditures estimates, would be reported separately.

Hospitals' reports for inpatient and outpatient services would be part of the uniform hospital reporting system.

Physicians and other providers would submit reports in a form to be specified by the Secretary.

The Secretary may, where appropriate, provide for the collection of data through surveys of a sample of health providers. Prior to April 15, 1997, the Secretary may use such other data collection and estimation techniques as may be appropriate.

Providers who fail to provide such information or who deliberately provide false information would be subject to civil monetary penalties not to exceed \$10,000 for each refusal or provision of false information.

Effective Date.—Effective upon the date of enactment.

Subtitle B. Allocation of health spending estimates to states

Sec. 5. Allocation of Health Spending Estimates to States

Present Law.—(a) Allocations to States.—No provision.

(b) Determination of State adjustment factors.—No provision.

(c) Adjustments for universal coverage.—No provision.

(d) Recommendations by commissions.—ProPAC and PPRC are independent commissions that provide annual recommendations to the Congress on issues relating to hospital and physician payments under Medicare, and to issues relating to health care services and financing.

Explanation of Provision.—(a) Allocations to States.—The national private per capita estimate would be allocated to each State to provide for monitoring of States' success in controlling costs, and to determine whether the standby Federal cost containment system would apply within a State.

For each year and for each State, beginning with 1996, the State private per capita estimate would be equal to the national private per capita estimate multiplied by an adjustment factor that reflects the relative cost and use of services by residents of the State.

The Secretary would, in conjunction with the publication of the national private per capita estimate, publish the allocation of the national private per capita estimate to each State. The Secretary would report such allocations to Congress and to each State.

(b) Determination of State adjustment factors.—In general, the Secretary would establish a State adjustment factor for each State in 1995. The adjustment factor would be equal to the ratio of the State private per capita estimate to the national private per capita estimate.

The Secretary would calculate the State private per capita health expenditure estimates for 1995 for each State in the same manner as the national private per capita estimate is calculated. Specifically, the Secretary would estimate per capita spending in each State in 1993, and trend these data forward to 1995. The State adjustment factor would be equal to the ratio of the State private per capita estimate to the national private per capita estimate. In determining these adjustment factors, the Secretary would establish them in a manner such that the population weighted average of the adjustment factors is equal to one.

In estimating the 1993 State private per capita estimates, the Secretary would adjust the data such that the private per capita estimate reflects the historic utilization patterns within the State, and the prices that would apply under the maximum payment rate system if the system applied in the State in 1995. The Secretary

also would adjust the State private per capita estimate to take into account differences among States in the in-State use of services by out-of-State residents, and the out-of-State use of services by State residents, such that the allocation in 1995 reflects services used by State residents anywhere in the United States.

In determining the number of persons residing in a State, the Secretary would use the most recent data available and would not rely strictly on the decennial census. The term resident in this section has the same meaning and definition as described in Title IV.

As under the system of national health expenditure estimates, the Secretary would not be permitted to adjust the State private per capita estimates or the adjustment factors once established. The only adjustment that would be permitted would be adjustments to correct errors in the estimation of the base year (1995) amounts. Specifically, the estimate for 1995 could be amended by the Secretary to correct errors in the estimation of initial spending relative to the predicted level.

In the case where the Secretary either adjusts the national private per capita estimate for 1995 or the State per capita estimates for 1995 (and the related adjustment factors), the Secretary would make conforming changes to the State per capita estimates for years after 1995.

States could apply to the Secretary to exclude certain health care spending from being considered in determining whether a State is within its growth limits in the case of costs related to demands of a sudden and temporary nature, such as epidemics or natural disasters. Costs relating to demands lasting more than six months would not be considered temporary.

(c) Adjustments for universal coverage.—Consistent with the adjustment to the national health spending estimates to reflect the effects of universal coverage, implementation of Medicare Part C, and the Medicare drug benefit, the adjustment factors for each State would be adjusted in the same manner and amount as the national estimate to reflect the impact of these changes.

(d) Recommendations by commissions.—ProPAC, PPRC, and DrugPRC would make periodic reports to the Congress on the allocation of the national health expenditure estimate to the States. These reports should include such recommendations as the Commissions deem appropriate.

Effective Date.—Effective upon the date of enactment.

Subtitle C. Standby Federal cost containment

Sec. 6. Application of Maximum Payment Rates in a State that Fails to Control Costs

Present Law.—(a) Evaluation of State performance.—No provision.

(b) Application of maximum payment rates in States that fail to control costs.—No provision.

Explanation of Provision.—(a) Evaluation of State performance.—Beginning in 1997, the Secretary annually would determine whether each State met its cost-containment objectives for the preceding year. The initial such determination would be with respect to 1996.

A State would have met its cost containment objectives if, for the preceding year, the average per capita spending for health services included within the expenditure estimating system is less than or equal to the State private per capita estimates for the year.

The Secretary would use data and information reported through the national health expenditures reporting system as the basis for this determination.

In accordance with procedures established by the Secretary, a State may apply to the Secretary to exclude costs attributable to health care needs of a sudden and temporary nature, such as epidemics or natural disasters, from the calculation determining whether a State has met its cost-containment objectives. Expenditures relating to health care needs extending over a period of more than six months would not be considered temporary.

(b) Application of maximum payment rates in States that fail to control costs.—If, beginning with 1999, health spending in a State is above the State's cost containment objectives during the year period, the Federal standby cost containment system based on maximum payment rates would apply in the State beginning on January 1 of the second following year. The first such year in which maximum payment rates could apply in a State would be 2001. Once applied, the maximum payment rates would remain in effect in the State, unless the State established an alternative system under title IV.

The maximum payment rates would not apply in States that have met their cost containment objectives, whether or not they have established, and are operating, an approved alternative system under title IV.

In the case of a State that is operating either an approved all-payer rate setting system, or a benefits management program, as defined in title IV, the system of maximum payment rates would not apply to payments for services provided under such approved systems. The determination of whether to apply the Federal standby cost containment system to such services would be based on the applicable tests for maintaining such approved systems described in title IV.

Effective Date.—Effective upon the date of enactment.

Subtitle D. Maximum payment rates

Sec. 7. Establishment of Maximum Payment Rates

Present Law.—(a) Publication.—No provision.

(b) Review and recommendations of commissions.—No provision.

Explanation of Provision.—(a) Publication.—For each year beginning with calendar year 1996, the Secretary would determine maximum payment rates and would publish such rates in the Federal Register. The maximum payment rate for a service would be defined as the maximum amounts that would be payable under a plan for the service, including cost-sharing and extra-billing amounts.

The maximum payment rates would not be binding on providers with regard to payments for services covered by private insurers during 1996, 1997 and 1998.

Proposed maximum payment rates would be published not later than April 1 of each year for the following year (September 1 for 1996). After consideration of public comments on the proposed rates, the Secretary would publish the final maximum payment rates not later than October 1 of each year for the following year. The Secretary would include in the publications of such rates a description of the payment methodology used in the establishment of the maximum payment rates, and, to the extent the final rates differ from the recommendations of the applicable commissions, an explanation of the Secretary's grounds for not following such recommendations.

(b) Review and recommendations of commissions.—By June 1, of each year, ProPAC, PPRC, and DrugPRC would report recommendations to Congress and the Secretary regarding the proposed maximum payment rates for the following year. These reports should include such recommendations as the Commissions deem appropriate.

Effective Date.—Effective upon the date of enactment.

Sec. 8. Relationship of Maximum Payment Rates to System of National Expenditure Estimates

Present Law.—The Secretary determines rates for payment under the Medicare program.

In the case of hospitals, the Secretary determines prospective payment rates payable for each hospital admission which are adjusted for: relative costs associated with different types of cases, organized into diagnosis-related groups (DRGs); relative labor-related costs associated with different geographic areas; indirect medical education costs; disproportionate share costs; and costs associated with cases that are excessively expensive or have a long length-of-stay. The Secretary has developed a prospective payment system for capital-related costs which is being phased in over a ten-year period which began in fiscal year 1992. Medicare pays its share of the direct costs of graduate medical education separately.

In the case of physician services, Medicare payment is based on the resource-based relative value scale (RB RVS). This system establishes relative payment amounts among procedures. Payments are adjusted between geographic areas to reflect differences in the costs of living, practice costs, and malpractice.

Medicare policies limit the actual charges for physician and certain other services.

Under Medicare, fees for other services are based on a variety of payment methodologies including fee schedules, reasonable charge limits, and payments based on retrospective costs.

Explanation of Provision.—The maximum payment rates for each year would be established for each class such that, if they were to apply in all States for the year, the national average private per capita expenditures for items and services in the class (and included in the national private per capita estimate) would be equal to the national private per capita estimate allocated to the class.

These rates would be calculated without regard to any temporary reductions in payment rates that may apply in a State resulting from the termination of a State's approved all-payer rate-setting

system or benefits management program as provided under title IV.

The methodologies used as the basis of the maximum payment rates generally would be based on the methodologies for making payments for services under the Medicare program, including Medicare Part C. Payments would be geographically adjusted in the same manner as under the Medicare program. The methodologies for making such payments would not necessarily have to be the same for all services within each class of services.

Effective Date.—Effective upon the date of enactment.

Sec. 9. Application and Enforcement of Maximum Payment Rates

Present Law.—No provision.

Explanation of Provision.—If the system of maximum payment rates applies in a State, providers would be: (1) required to charge based on the maximum payment rate methodology; (2) prohibited from charging amounts in excess of the maximum payment rates; and (3) prohibited from collecting amounts in excess of the maximum payment rates. Individuals, health plans and all other payers would not be liable for amounts that exceed the maximum payment rates.

The maximum payment rates would not apply to services covered under the Medicare program, including Medicare Part C.

Civil money penalties equal to \$100 for each improper charge would be imposed on providers who charged in excess of the maximum payment amounts. If a provider collected excess amounts, and did not refund the excess within thirty days of being notified that an excess amount was collected, a civil monetary penalty equal to three times the excess amount charged, or if greater, \$500, would be imposed. Any funds collected as a result of this provision would be deposited into the Anti-fraud and Abuse Trust Fund established by this legislation.

Effective Date.—Effective upon the date of enactment.

Sec. 10. Methodology for Determining Maximum Payment Rates for Hospital Services

Present Law.—(a) General Rule for Hospital Payments.—Under Medicare, the Secretary determines prospective payment rates for inpatient hospital services based upon an average payment per admission adjusted for case mix using diagnosis-related groups (DRGs).

The Secretary has determined a standardized payment amount for Medicare patients which is based initially upon average payments in a base year, and which is updated annually.

Medicare rates are set separately for hospitals in large urban areas, for other urban hospitals, and for rural hospitals, although the separate rural standardized amount will be phased out by FY 1995.

Under Medicare, services provided on an outpatient basis during the three days immediately prior to a hospital admission are not separately reimbursed if the services are related to the admission.

(b) Adjustments to hospital payments.—Under Medicare, a series of adjustments are made to the standardized amounts. Payment

rates are adjusted: (i) by geographic area for wages and non-labor related costs; (ii) for the indirect costs of medical education; and (iii) for certain high-cost or long length-of-stay cases known as outliers. Payments for cases transferred to another hospital are based on per diem amounts, up to the full DRG payment for the case. Beginning in fiscal year 1992, prospective payment for capital costs is being phased in over a ten-year period. Hospitals are reimbursed on a cost-related basis for the direct costs of graduate medical education. Growth in such costs is limited to the consumer price index.

(c) PPS-exempt hospital payments.—Under Medicare certain specialty hospitals and distinct-part specialty units of general hospitals are not paid on the basis of DRG-adjusted per admission payments. These exempt hospitals and units are children's hospitals, psychiatric hospitals and units, rehabilitation hospitals and units, long-term hospitals, and certain cancer research hospitals so designated prior to December 31, 1990. These hospitals are reimbursed on the basis of reasonable costs, but payment is limited by a ceiling on the rate of increase in such costs (the "TEFRA limits").

Explanation of Provision.—(a) General rule for hospital payments.—The maximum payment rates for inpatient hospital services would be determined based upon an average payment per admission adjusted for case mix using diagnosis-related groups (DRGs).

The Secretary would determine an initial standardized amount for non-Medicare patients which would result in spending in the private sector that is consistent with the baseline historical per capita health spending estimate for 1995. In determining the standardized amounts, the Secretary would include revenues associated with services provided on an outpatient basis during the three days immediately prior to a hospital admission if the services are related to the admission.

Rates would be set separately for hospitals in large urban areas and for all other hospitals. New DRGs would be developed as necessary for the under-65 population, and new weights would be developed for all DRGs to properly reflect resource consumption patterns among this population, including separate DRG categories and weights for children.

(b) Adjustments to hospital payments.—In computing the maximum payment amounts, a series of adjustments would be made to the standardized amounts. Payment rates would be adjusted: (i) by geographic area for wages and for non-labor input prices; (ii) for the indirect costs of graduate medical education (as described in subtitle B of title VII); (iii) for hospitals serving a disproportionate share of low-income patients, and (iv) for certain high-cost or long length-of-stay cases known as outliers.

Maximum payment rates for transfer cases would also be defined, based on Medicare payment rules. It is anticipated that the Secretary would use the same methodology and transition as is used under the Medicare program, to determine payment for capital-related costs.

The maximum payment rates per admission would be adjusted on a hospital-specific basis to reflect the direct costs of graduate medical education (as described in subtitle B of title VII).

The Secretary would be authorized, but not required, to adjust the maximum payment rates to take into account the needs of regional and national referral centers, sole community hospitals, and essential access hospitals as such terms are defined under Medicare.

(c) PPS-exempt hospital payments.—The maximum payment rates for hospitals currently exempt from the prospective payment system under Medicare would be determined on a per admission basis for each hospital, based on the allowable operating receipts of the hospital. These per diem rates would apply until prospective payment methods are developed and implemented.

Effective Date.—Effective upon the date of enactment.

Sec. 11. Methodologies for Determining Maximum Rates for Physician and Other Professional Medical Services

Present Law.—In the case of physician services, Medicare payment is based on the resource-based relative value scale (RB RVS). This system establishes relative payment amounts among procedures. Payments are adjusted between geographic areas to reflect differences in the costs of living, practice costs, and malpractice.

Medicare policies limit the actual charges for physician and certain other services.

Under Medicare, fees for other professional services are based on a variety of payment methodologies including fee schedules and reasonable charge limits.

Explanation of Provision.—In general, the maximum payment rates would be determined using a resource-based relative value scale (RB RVS) for physician and other professional medical services following the methodology established under Medicare. The Secretary would establish and publish new relative value units for services not currently covered under Medicare.

The Secretary would publish the definitions, relative value units, and payments policies necessary for private payers to apply the maximum payment rates for physician and other professional medical services.

The maximum payment rates for services would be determined by establishing a maximum conversion factor which, when multiplied by the relative value units of services estimated to be provided, would result in per capita expenditures consistent with the national private per capita estimate for each year.

The maximum payments rates would be calculated to include the allowed extra-billing, determined based on the limits applicable under Medicare. In addition, the maximum payment rates would be adjusted geographically and include allowances for bonus payments applicable to services provided in underserved areas in the same manner as for physician services under Medicare.

Effective Date.—Effective upon the date of enactment.

Sec. 12. Methodologies for Determining Maximum Rates for Other Services

Present Law.—(a) Outpatient hospital and other services reimbursed on a cost-related basis under Medicare.—Medicare payments for services provided in hospital outpatient departments

(OPDs) are based on a variety of different payment methodologies. Some services, such as laboratory tests, are reimbursed based on fee schedules, others are based on costs subject to certain cost limits, while others are paid on a cost-related basis. OBRA '90 required the Administration and ProPAC to conduct certain studies relating to the development of prospective payment methodologies for all services provided in hospital OPDs.

Federally-qualified health centers (FQHCs) are paid on a reasonable-cost basis.

(b) Diagnostic testing services.—(i) Laboratory tests.—Under Medicare, laboratory services are based on a laboratory fee schedule. Such services must be directly billed to Medicare by the entity that performs the service.

(ii) Other diagnostic tests.—Other diagnostic tests are paid on the basis of either the RB RVS or reasonable charges.

(c) Durable medical equipment.—Medicare payments for durable medical equipment (DME) are on the basis of fee schedules. Different fee schedules apply depending upon the type of DME and upon whether the equipment is purchased or rented.

(d) Payments for prescription drugs.—In general, Medicare does not cover outpatient prescription drugs. Title III of this bill would establish coverage for prescription drugs under Medicare, and establishes limits on what Medicare would pay for these drugs.

(e) Payments for other services covered under Medicare.—Payments for other professional services are made on the basis of fee schedules or reasonable charges, subject to certain limits.

(f) Development of prospective payment methodologies.—Under Medicare, payments for skilled nursing facilities, home health services, and certain other services are based on retrospective costs. The Omnibus Reconciliation Act of 1990 (OBRA '90) required the Administration and ProPac to conduct certain studies relating to the development of prospective payment methodologies for these services.

Explanation of Provision.—(a) Outpatient hospital and other services reimbursed on a cost-related basis under Medicare—The maximum payment rates for outpatient hospital fees and fees for other cost-related services under Medicare would, pending development of a prospective payment system, be set by limits on a year-to-year basis such that expenditures for these services are consistent with the national health expenditure estimate.

FQHC services would be reimbursed on a reasonable-cost basis by all payers. Reasonable costs would be determined in the same manner as under Medicare.

(b) Diagnostic testing services.—(i) Laboratory tests.—Maximum payment rates would be set based on the methodology used to determine the Medicare laboratory fee schedule, adjusted as necessary to be consistent with the national private per capita estimate. All services covered by a third-party payer would be required to be directly billed to the insurer by the entity or individual that performed (or supervised) the performance of the tests, consistent with the requirements under Medicare, and the requirements relating to administrative simplification under title IX.

(ii) Other diagnostic tests.—Maximum payment rates would be set using the same methodology that applies under Medicare. In

general, the maximum rates would be based on fee schedule or reasonable charge limits, with the actual rate being determined in a manner consistent with the national private per capita estimate.

(c) Durable medical equipment.—Maximum rates for DME would be set based on Medicare fee schedules and policies, adjusted as necessary to be consistent with the national per capita estimate.

(d) Payments for prescription drugs.—The methodology for establishing the maximum payment rates for prescription drugs would follow the methodology for limiting medicare payments for prescription drugs, as described in title III. The limits would be set to be consistent with the national private per capita estimate.

(e) Payments for other services covered under Medicare.—The maximum payment rates for other services paid on a reasonable-charge basis under Medicare would be based on the methodologies used in establishing such Medicare limits. Such limits could be based on prevailing charge limits or fee schedules, as provided under Medicare, adjusted to be consistent with the national private per capita.

(f) Development of prospective payment methodologies.—The Secretary would, by January 1, 1997, develop prospective payment methodologies for setting maximum payment rates for services for which an appropriate methodology does not exist currently under Medicare.

In the case of any service within a class of services for which a prospective payment system is established for Medicare, the Secretary would revise the methodology for establishing maximum payment rates under this title to conform to the methodology used under Medicare.

In developing a prospective payment methodology for children's hospitals, the Secretary would be required to develop a system which used a hospital-specific methodology based on the resource requirements of children developed using pediatric-specific data.

Effective Date.—Effective upon the date of enactment.

Sec. 13. Limits on Payments to Capitated Managed Care Plans

Present Law.—Medicare establishes per capita payment rates for different classes of beneficiaries enrolled in eligible organizations with contracts to provide services on a capitated or risk basis. Enrollees are grouped by age, sex and other factors determined by the Secretary to be appropriate. The payment rate for each class is equal to 95 percent of the average adjusted per capita cost (AAPCC) for that class, a projection of what Medicare would spend to provide covered services to a comparable group of beneficiaries not enrolled in these eligible organizations.

Explanation of Provision.—The Secretary would establish a system of determining maximum payment rates for plans contracting to provide services on a capitated or risk basis. This methodology would be based on the Medicare AAPCC methodology, but would reflect services that would be provided to a representative population not enrolled in such plan. The initial maximum payment rates to such a risk-contracting plan would be based on 95 percent of the comparable cost of providing services to individuals not enrolled in such plans. In subsequent years, the payments would be adjusted to be consistent with updates to the maximum payment

rates for services provided, or paid, on a fee-for-service basis, consistent with the national private per capita estimate.

Effective Date.—Effective upon the date of enactment.

Sec. 14. Limits on Payments by Property and Casualty Insurers for Services

Present Law.—No provision.

Explanation of Provision.—Without regard to whether the stand-by Federal cost containment system applies in a State, fees by property and casualty insurers for medical services could not be less favorable than the fees that would be paid by the health insurance plan in which the individual is enrolled for similar services.

Effective Date.—Effective January 1, 1998.

Subtitle E. Administrative and judicial review

Sec. 15. Administrative and Judicial Review

Present Law.—Medicare's prospective payment system for inpatient hospital services was enacted in the Social Security Amendments of 1983. In this Act, certain elements of the hospital payment reform were exempt from both administrative and judicial review. When Medicare's physician payment reform was enacted in the Omnibus Reconciliation Act of 1989, a similar provision was included that prohibited administrative and judicial review of the Secretary's estimates of certain components of the reformed payment system.

Explanation of Provision.—There would be no administrative or judicial review of the Secretary's determination of (i) the maximum payment rates; (ii) DRG or RB RVS values established for services; and (iii) initial estimates of the national health expenditure estimates or the allocation of such estimates to classes of health services or to the States.

Effective Date.—Effective upon the date of enactment.

Subtitle F. National Health Cost Commission

Sec. 16. National Health Cost Commission

Present Law.—(a) Establishment of commission.—No provision.

(b) Special report in 2000.—No provision.

Explanation of Provision.—(a) Establishment of commission.—A National Health Cost Commission would be established, on January 1, 1997. The Commission would consist of nine members, appointed by the President. The members would be selected based on their expertise and national recognition in the fields of health economics, provider reimbursement, health insurance, health benefits design, and related fields. In appointing members to the Commission, the President would be required to seek recommendations from the Speaker of the House, and the majority and minority leaders of both Houses of Congress.

The Commission would conduct analyses of the health care cost and revenue data reported to the Secretary under section 4 of Subtitle A.

On April 1 of each year, beginning in 1998, the Commission would submit a report to Congress on health care costs in the United States. The report would include analyses of (1) the rate of growth in health care costs by type of provider, by type of payer, and by State; (2) the success or failure of the private sector in staying within national health estimates set by the legislation on a state-by-state basis; (3) the impact of universal coverage on health care costs and on payments for services by private payers; and (4) the future rate of growth in health care costs, based on projections of historical trends, using the economic assumptions of the Congressional Budget Office.

(b) Special report in 2000.—In 2000, the report of the Commission would include a specific finding regarding whether a system of cost containment should be imposed on health care services provided under private health insurance plans. This recommendation would be based on the most recent data available at that time.

The Commission could recommend that the system of private sector cost containment included in the mark be allowed to go into effect, or the Commission could recommend an alternative system. The Commission would be required to include in its report a detailed legislative proposal to implement its recommendations. The recommendations could include any cost containment measure the Commission wished to recommend, but could not relate to a change in the guaranteed national benefit package.

Effective Date.—Effective upon the date of enactment.

Sec. 17. Expedited Consideration of Recommendation

Present Law.—No provision.

Explanation of Provision.—The Commission's recommendations, contained in the special report in 2000, would be considered by the Congress following a "fast track" procedure.

The Chairmen of the relevant Committees in each House would introduce the Commission's legislative recommendations within seven days.

The Committees in each House would have 45 days to consider the provisions within their jurisdiction. If a Committee failed to report the legislation within this time period, it would automatically be discharged from further consideration. The Committees would be permitted to amend the legislation relating to the Commission's recommendations.

No amendments would be in order on the floor of each House if the bills reported from the Committees are the same as the Commission's recommendations. If a Committee's bill differed from the Commission's recommendations, the rule in each House would provide for the Commission's recommendations to be considered on the floor as an amendment in the nature of a substitute for the related provisions of the bill. Debate would be limited in each House to no more than 20 hours.

If, based on the Commission's recommendations, the bill introduced is a revenue bill, the Senate would be given an additional 15 days following House passage for consideration by the relevant Senate Committees of jurisdiction, and 15 days for consideration of the bill on the floor.

In order for the submission of the Commission's recommendations to trigger these procedures, the recommendation of the Commission would have to be accompanied by a statement, provided by the Director of the Congressional Budget Office, that the provisions recommended in the bill as introduced would meet the cost-containment objectives set forth by the Commission.

Effective Date.—Effective upon the date of enactment.

Title VII. Public Health Initiatives

Subtitle A. Health workforce priorities

Sec. 1. National Healthcare Workforce Plan

Present Law.—(a) Development of plan.—No provision.

(b) Plan objectives and special considerations.—No provision.

(c) Development of methodology.—No provision.

(d) Report to Congress.—No provision.

Explanation of Provision.—(a) Development of plan.—The Secretary would develop a national healthcare workforce plan. The plan would specify the total number of physicians that should be trained, and how this total should be allocated among specialties. The plan also would estimate the number of non-physician professionals including nurse practitioners and advanced practice nurses, that should be trained and consider ways to encourage training of appropriate numbers of such professionals.

In developing the plan, the Secretary would consult with consumers, experts in health workforce needs, teaching physicians, the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, physicians in private practice, nurses, representatives of health insurers, including HMOs and other managed care plans, and other organizations representing physicians.

(b) Plan objectives and special considerations.—The national healthcare workforce plan would provide that at least 55 percent of all residents beginning training on or after July 1, 1998 would be in primary care specialties. For this purpose, primary care would be defined as including the specialties of family medicine, general internal medicine, general pediatrics, geriatrics, preventive medicine, obstetrics and gynecology, and osteopathic general practice. In developing the plan, the Secretary also would give special consideration to other physician specialties for which inadequate numbers of physicians are being trained.

The Secretary would be permitted to alter the proportion of residents trained in primary care to provide for an appropriate transition to the national goal, or to reflect changing needs for different numbers and types of physicians.

(c) Development of methodology.—The Secretary would develop a methodology for a national program to approve or otherwise limit the number of residency positions in a specialty that would be considered for the purpose of determining adjustments in payments or maximum payment rates under Medicare and private health plans. The limitations so imposed would be consistent with the national healthcare workforce plan. The methodology may include that, as a condition of receiving payments for the direct costs of graduate medical education, an institution would have to enter into an

agreement with the Secretary so that the number of enrollees in their training programs would be consistent with the national healthcare workforce plan. The methodology would provide for appropriate opportunities for training in osteopathic specialties. In addition, the methodology would provide for appropriate support of training in sites other than hospitals.

The methodology would include specific criteria that would be used to approve such positions. These criteria should include consideration of the geographic distribution of physicians, quality of residency training programs, training of physicians in sites other than hospitals, and the need to encourage the training of minority physicians. In developing the methodology, the Secretary would be required to consult with experts in graduate training and education, including the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, and other organizations involved in the accreditation of residency positions.

(d) Report to Congress.—The Secretary would submit a report and a detailed description of the healthcare workforce plan and implementation of the methodology to the Congress by December 31, 1995. The report would include an analysis of the impact on teaching hospitals and other training programs of limiting support for training, consistent with the national healthcare workforce plan.

Effective Date.—Effective upon the date of enactment.

Sec. 2. Allocation of Residency Positions under National Healthcare Workforce Plan

Present Law.—No provision.

Explanation of Provision.—The Secretary would implement a program to limit the number of training positions in accordance with the national health care workforce plan, based on the methodology developed under such plan.

Effective Date.—Effective upon the date of enactment.

Sec. 3. Payments Under the Healthcare Workforce Account and Maximum Payment Rates for Graduate Medical Education

Present Law.—(a) Direct graduate medical education payments from the Account.—Medicare pays its share of the direct costs of graduate medical education in teaching hospitals. In general, private insurers do not make a separately identifiable payment for these costs. Under Title VI of this bill, maximum payment rates would be established that would apply to payments made by private insurers. These rates would include specific adjustments for the direct costs of graduate medical education.

(b) Indirect graduate medical education payments from the Account.—Medicare also pays its share of the indirect costs of graduate medical education in teaching hospitals. In general, private insurers do not make a separately identifiable payment for these costs. Under Title VI of this bill, maximum payment rates would be established that would apply to payments made by private insurers. These rates would include specific adjustments for the indirect costs of graduate medical education.

(c) Adjustments to the maximum payment rates for the direct costs of graduate medical education.—No provision.

Under Title VI of this bill, maximum payment rates would be established that would apply to payments made by private insurers.

(d) Adjustments to the maximum payment rates for the indirect costs of graduate medical education.—No provision.

Under Title VI of this bill, maximum payment rates would be established that would apply to payments made by private insurers.

Explanation of Provision.—(a) Direct graduate medical education payments from the Account.—The Secretary would make payments to hospitals from the Healthcare Workforce Account in the Healthcare Trust Fund (established under title XI) relating to the private share of the direct costs of graduate medical education. In determining the private share of these costs, the Secretary would use same rules for determining the FTE amounts and number of FTEs as apply under Medicare.

The Secretary would estimate each calendar year, the aggregate amount of the private share of the direct costs of graduate medical education for the year. Based on the anticipated deposits into the Account for the year, the Secretary would determine a payout ratio, defined as the ratio of the deposits over the total private share of the direct costs of graduate medical education, but not greater than 1.0.

Effective for portions of cost reporting periods beginning on or after January 1, 1996 and ending before January 1, 1999, hospitals that receive payments from Medicare for the direct costs of graduate medical education would also receive payments for the portion of these costs that are related to patients who are not insured by Medicare or Medicaid. The portion of the private share that would be paid would be equal to the private share times the payout ratio.

As a condition of receiving such payments, hospitals would have to provide the Secretary with such information as the Secretary may require. Such payments would only be made with respect to residency positions approved by the Secretary under the implementation of the national healthcare workforce plan.

(b) Indirect graduate medical education payments from the account.—During a year for which payments into the Account during such calendar year would not be fully disbursed for payments relating to the private share of the direct costs of graduate medical education, the Secretary would provide for payments to teaching hospitals related to the indirect costs of graduate medical education. The Secretary would estimate a hospital-specific payment adjustment per admission. The amounts would vary between hospitals based on each hospital's intern and resident-to-bed ratio, in the same manner as under Medicare (as amended).

The Secretary would estimate a separate payout ratio (not greater than 1.0) for indirect medical education, based on the residual amount available in the Account for the year and the Secretary's best estimate of the aggregate amount of the private share of the indirect costs of graduate medical education.

The Secretary would establish a process by which hospitals would apply for payments. The timing of the application process and the payments would be determined at the discretion of the Secretary, based on the amount of excess funds available, and consistent with maintaining the solvency of the trust fund.

As a condition of receiving such payments, hospitals would have to provide the Secretary with such information as the Secretary may require. In addition, after June 30, 1998, such payments would only be made with respect to residency positions approved by the Secretary under the implementation of the national healthcare workforce plan.

(c) Adjustments to the maximum payment rates for the direct costs of graduate medical education.—The maximum payment rates per admission established for inpatient hospital services would be adjusted to reflect the direct costs of graduate medical education. The adjustment for the direct costs of graduate medical education would be based on the methodology used by Medicare in determining the reasonable costs per FTE resident, and for determining the number of FTE residents (as amended).

The adjustment to the maximum payment rates per admission would be calculated on a hospital-specific basis. The amount of the adjustment would be equal to the private sector share of these costs divided by the average number of admissions per year over the most recent three-year period.

Only residency positions approved by the Secretary as being consistent with the national healthcare workforce plan and their related costs would be considered in determining the amount of this adjustment. In the case of institutions that are eligible for transition payments relating to the loss of residency positions, the maximum payment rates would be adjusted to include such transition payments.

The amount of the adjustment to the maximum payment rates so determined would be reduced by the amount paid to the institution for the direct costs of graduate medical education out of the Health Care Workforce Trust Account.

The Secretary would publish the adjustment per admission for the direct costs of graduate medical education for each hospital by October 1 of each year.

(d) Adjustments to the maximum payment rates for the indirect costs of graduate medical education.—The maximum payment rates per admission established for inpatient hospital services would be adjusted on a hospital-specific basis to reflect the indirect costs of medical education in the same manner as under Medicare, as amended by this bill. Only residency positions approved by the Secretary as being consistent with the national healthcare workforce plan would be considered in determining the amount of the IME adjustment.

The amount of the adjustment to the maximum payment rates so determined would be reduced by the amount paid to the institution for IME out of the Health Care Workforce Account.

The Secretary would publish the IME adjustment for each hospital by October 1 of each year.

Effective Date.—(a) applies to portions of cost reporting periods beginning on or after January 1, 1996. (b) applies to discharges on or after January 1, 1996. (c) and (d) applies to maximum payment rates established for years after 1995.

Sec. 4. Payments under Medicare; Implementation of National Plan

Present Law.—Medicare makes payments to teaching hospitals for its share of the direct costs of graduate medical education. The amount is based on the average cost per full time equivalent (FTE) resident, multiplied by the number of FTE residents.

In determining the amount of Medicare payments, based on the number of FTE residents, certain residents are not counted. Specifically, the number of FTE residents includes only those trainees who have not completed the required number of years of training to be eligible for certification by a medical specialty board. Residents who have elected to continue their training are not included. In addition, residents who have completed five years of post graduate training are not included in the count of FTE residents. Payments are not made for residents who are foreign medical graduates that have not passed an appropriate examination.

Explanation of Provision.—Beginning with residents whose training begins on or after July 1, 1998, Medicare payments would be based only on the number of residents in residency slots approved by the Secretary to be consistent with the national healthcare workforce plan.

Effective Date.—Effective upon the date of enactment.

Sec. 5. Transitional Payments for Hospitals Losing Specialty Positions

Present Law.—No provision.

Explanation of Provision.—The Secretary would make transitional payments to institutions that operate programs that lose specialty training positions as a result of allocations by the Secretary. Applications for payment must be submitted on a timely basis, and contain assurances of compliance with the national healthcare workforce plan that are satisfactory to the Secretary.

The amount of the payments would be based on the number of FTE specialty positions lost, multiplied by a transition proportion described below, and then further multiplied by the FTE payment amount. The number of specialty positions lost would be equal to the difference between the number of FTE specialty positions in the institution during the 1993–1994 academic year, and the number of FTE positions approved by the Secretary for the academic year in question.

For Medicare, the FTE payment amount would be equal to the amount that Medicare otherwise would pay for one FTE resident in the institution. With regard to payments from the National Healthcare Workforce Trust Fund (established in section 7 of this title), the FTE payment amount would be the amount that would otherwise be paid to the institution for one FTE resident per admission.

Payments may begin in calendar year 1998, or in the first year that the programs of the institution experience a net reduction in specialty positions because of the allocations by the Secretary. The transition proportion would be defined as 100 percent in the first year, and would decline in equal increments to zero percent in the fifth year.

Effective Date.—Effective upon the date of enactment.

Sec. 6. Determination under Medicare of Number of Full-time equivalent Residents

Present Law.—Medicare makes payments to teaching hospitals for its share of the direct costs of graduate medical education. The amount paid is based on the average cost per full time equivalent (FTE) resident, multiplied by the number of FTE residents.

The per-resident costs are determined for each hospital in a base year, updated each year by the change in the consumer price index (CPI-U). For hospital cost-reporting periods beginning in fiscal years 1994 and 1995, the per-resident payment amounts for residency positions in programs other than primary care and obstetrics and gynecology were not updated. As a result, the per-resident payment amounts vary by type of resident within an institution.

Explanation of Provision.—In determining the number of FTE residents, the Secretary would weight the actual number of FTE residents to provide for increased payments for each resident in primary care and obstetrics and gynecology. Specifically, each full time equivalent resident in primary care and obstetrics and gynecology would be counted as 1.1 FTE residents. Each other resident in their initial residency period would be counted as 0.8 FTEs. Residents passed their initial residency period would be counted as 0.5 FTE.

Primary care residents would be defined as residents in general internal medicine, general pediatrics, family practice, geriatrics, preventive medicine, osteopathic general practice, and obstetrics and gynecology.

Effective Date.—Effective for portions of cost reporting periods beginning on or after January 1, 1996.

Sec. 7. Payments to Federally Qualified Health Centers

Present Law.—Medicare makes payments to Federally Qualified Health Centers (FQHCs) based on an all-inclusive rate calculated on the FQHCs reasonable costs. The all-inclusive rate is subject to a limit within each geographic area. The direct costs of graduate medical education are considered to be a reasonable cost. However, the application of the limit generally precludes FQHCs from having the costs of graduate medical education recognized in their payment rates.

Explanation of Provision.—All costs of FQHCs associated with participation in an approved residency program would be considered allowable as a Medicare cost. Such costs would reflect the portion of time the resident spends at the FQHC site. The Secretary would provide for a facility-specific payment adjustment in the per-visit payment rates to reflect the direct and indirect costs of such training programs. The adjustment would take into account the additional direct and indirect costs associated with the training of interns and residents.

Effective Date.—Effective for services provided on or after January 1, 1996, and to the determination by the Secretary of maximum payment rates for years beginning with calendar year 1996.

Sec. 8. Medicare Demonstration Regarding Consortia of Hospitals

Present Law.—Medicare pays its share of the direct costs of graduate medical education in teaching hospitals. Medicare also pays its share of the indirect costs of graduate medical education in teaching hospitals through the IME adjustment to the prospective payment amounts paid per discharge.

Explanation of Provision.—The Secretary would provide for¹ the establishment of demonstration projects for health care training consortia for the purpose of testing and evaluating mechanisms to increase the number and percentage of medical students entering primary care practice through the use of graduate medical education funds.

Each health care consortium would include, but not limited to, one or more teaching hospitals. Each consortium would submit to the Secretary an application containing such information as the Secretary may require, including an explanation of a plan for evaluating the project. Training in a consortia would be required to conform with the overall objectives of the healthcare workforce plan developed by the Secretary. Until such plan is established, each consortium would be required to train at least 55 percent of its residents in primary care (as defined in regards to the national healthcare workforce plan). In implementing the national healthcare workforce plan, the Secretary would approve residency positions for a consortium as if it were a single institution. The consortia would then be permitted to allocate such approved positions within its member institutions and training sites.

For each consortium participating in the demonstration program, the Secretary would make payments for the direct and indirect costs of graduate medical education (from Medicare as well as the Healthcare Workforce Trust Fund) to the consortium. The consortium would be permitted to designate which hospital in the consortium each resident is assigned to for the purpose of calculating the direct and indirect graduate medical education payments. In addition, such payments would be made without regard to the site where the resident actually was being trained. The total amount of such payments would be limited by the following factors. First, the total number of FTE residents upon which such payments would be based could not exceed the number of FTE residents in the consortium's hospitals during the twelve month period ending June 30, 1994. In addition, the amount would be limited by the distribution of residents among member hospitals during the twelve-month period ending June 30, 1994.

The Secretary would make payments to each consortium through an entity identified by the consortium. The consortium would have discretion over the use of such payments.

Each demonstration under this section would be limited to a 10-year period. The Secretary would be permitted to terminate a project if the Secretary determined that the consortium was no longer in substantial compliance with the terms of the project as described in the application to the Secretary.

Effective Date.—Effective upon the date of enactment.

Sec. 9. Study of Payment for Medical Education in Sites Other than Hospitals

Present Law.—In general, Medicare does not pay for the costs related to graduate medical education in sites other than hospitals.

Explanation of Provision.—The Secretary would conduct a study, and make recommendations to Congress, of the feasibility and desirability of making payments for the direct and indirect costs of graduate medical education with respect to residents trained in sites other than hospitals. The study would include an assessment of new payment methodologies to insure funds are paid to entities which incur the cost of such training and to encourage the training of primary care physicians.

Effective Date.—Effective upon enactment.

Subtitle B. Additional provisions regarding primary care

Sec. 10. Changes in Underserved Area Bonus Payments

Present Law.—(a) Direct bonuses to primary care services.—Medicare makes bonus payments to physicians providing services in geographic areas that are designated as health professional shortage areas. The bonus amount is equal to ten percent of the amount that would otherwise be paid to the physician for services.

(b) Extension of bonus payments.—The designation of an area as a health professional shortage area is periodically reviewed. Areas that gain health professionals may lose their designation, in which case providers in such area would no longer be eligible to receive the bonus payments.

Explanation of Provision.—(a) Direct Bonuses to Primary Care Services.—The amount of the bonus paid by Medicare for physician primary care services would be increased to 20 percent of the amount that would otherwise be paid to the physician for services. The bonus payments for specialty services in urban areas would be eliminated, while bonus payments for specialty services in rural areas would remain at ten percent.

(b) Extension of bonus payments.—Bonus payments under Medicare would continue to be paid to eligible providers who serve in health professional shortage areas for a period of three years after the area loses its designation as a shortage area.

Effective Date.—(a) would be effective for services provided on or after January 1, 1998. (b) would be effective for services provided on or after January 1, 1996.

Sec. 11. Payments for Medical Schools

Present Law.—No provision.

Explanation of Provision.—The Secretary of HHS would make funds from the Undergraduate Medical Education Account in the Healthcare Trust Fund, established in title XI, available to support undergraduate medical education. The amount of such funds provided each year would be equal to the estimated deposits into the Account.

In order to be eligible to receive funds, a medical school would: (1) be required to maintain an active program of recruitment of under-represented minorities (meeting such requirements as de-

fined by the Secretary; and (2) be required to maintain a program to encourage students to choose primary care residencies (meeting such requirements as defined by the Secretary).

The funds would be distributed based upon a formula to be developed by the Secretary. In developing the formula, the Secretary would be required to take into consideration: (1) the proportion of students in the school who are under-represented minorities; and (2) the number of students who chose primary care residencies (as defined in the national health care workforce plan) upon graduation. The Secretary would design the formula to provide incentives to medical schools who are making substantial progress towards assuring that under-represented minorities are no longer under-represented and assuring that at least 55 percent (or such proportion as the Secretary determines is appropriate under the national healthcare workforce plan) choose primary care residencies upon graduation.

Effective Date.—Effective on January 1, 1996.

Sec. 12. Study of Funding Needs of Health Professions Schools

Present Law.—No provision.

Explanation of Provision.—The Secretary would study the needs of schools that provide training of healthcare professionals, including but not limited to medical schools, dental schools, and schools of public health, taking into account: uncompensated costs of providing health care; costs resulting from reduced productivity due to teaching responsibilities; increased costs of caring for the health needs of patients with severe medical complications; the uncompensated costs incurred by faculty, residents and students in providing consultations for hospitalized patient; and the uncompensated costs of clinical research. The Secretary would report to Congress appropriate recommendations as to whether a distinct funding source is warranted for the institutions considered as part of the study, what such a funding source should be, and a methodology for distributing funds to the schools considered as part of the study. The Secretary would submit a report to the Congress, including such recommendations as the Secretary considers appropriate, within 18 months of enactment.

Effective Date.—Effective upon the date of enactment.

Subtitle C. Essential health facilities

Sec. 13. Essential Access Community Hospitals

Present Law.—(a) Grants to States and facilities.—The Omnibus Budget Reconciliation Act of 1989 established the Essential Access Community Hospital program. Under this program, up to 7 States may be designated by the Secretary to receive grants to develop rural health networks consisting of essential access community hospitals (EACHs) and rural primary care hospitals (RPOCHs).

(b) Authorization of appropriations.—Authorization of appropriations for fiscal years 1990, 1991, and 1992 is \$10 million a year for grants to States and \$15 million a year for grants to hospitals.

(c) Designation of urban hospitals as EACHs.—The Secretary may designate an urban hospital as an essential access community

hospital if it meets the criteria for designation as a rural referral center.

(d) Designation of EACHs in States.—The Secretary may only designate a hospital as an essential access community hospital if it is located in a State receiving an EACH program grant.

(e) Written policies in RPCHs.—Rural primary care hospitals are required to have written policies governing the provision of services, and have a physician, physician assistant, or nurse practitioner responsible for the execution of those policies.

(f) Limit on inpatient beds in RPCHs.—A rural primary care hospital may not provide more than 6 inpatient beds, meeting such conditions as the Secretary may establish. RPCHs are authorized to maintain “swing beds” as skilled nursing beds or to operate a distinct-part skilled nursing facility.

(g) Limit on length of stay in RPCHs.—In order to receive designation by a State as a rural primary care hospital, a facility must meet certain criteria, including a requirement that inpatient stays not exceed 72 hours.

(h) Application of cost-sharing requirements.—Medicare inpatient hospital benefits are subject to the inpatient hospital deductible and to coinsurance after 60 days of hospitalization during a spell of illness.

(i) Payment for outpatient services.—Payments for outpatient services in a rural primary care hospital prior to 1993 are determined either by a cost-based facility fee or an all-inclusive rate, as elected by the RPCH. The Secretary is required to develop and implement by January 1, 1993, a prospective payment system for outpatient services provided in an RPCH.

(j) Rural health plan.—A State is eligible to participate in the Essential Access Community Hospital program if the State has developed, or is in the process of developing, a rural health plan that provides for the creation of one or more rural health networks, promotes regionalization of rural health services in the State, improves access to hospital and other health services for rural residents of the State and enhances the provision of emergency and other transportation services related to health care.

(k) Payment of essential access community hospitals.—Medicare payments for hospitals designated by the Secretary as Essential Access Community Hospitals are made in the same manner as payments to hospitals designated as sole community hospitals.

Explanation of Provision.—(a) Grants to States and Hospitals.—All States would be eligible for grants under the program.

(b) Authorization of appropriations.—Authorization for appropriations would be continued at current levels (\$10 million a year for grants to States and \$15 million a year for grants to hospitals) through fiscal year 1995. Authorization of appropriations for State planning activities for the creation of rural health networks would be increased to \$50 million per year for fiscal years 1995 through 1999.

Authorization for appropriation of grants to hospitals, facilities, and consortia for the establishment of rural health networks would be increased to \$40 million per year, for fiscal years 1995 through 1999.

(c) Designation of urban hospitals as EACHs.—The Secretary would be authorized to designate an urban hospital as an essential access community hospital if the hospital otherwise meets the criteria for designation. However, urban hospitals would not be eligible for a change in Medicare payment as a result of the designation.

(d) Designation of EACHs in States.—A State receiving a grant under the EACH program could designate a facility in an adjoining State as an essential access community hospital or a rural primary care hospital if the facility is otherwise eligible for designation. The Secretary would be authorized to designate a facility as an essential access community hospital or a rural primary care hospital if the facility is not in a State receiving an EACH program grant and if the facility is a member of a rural health network of a State receiving a grant. A State may not designate an EACH unless the State, in accordance with the rural health plan, has also designated at least one RPCH and both facilities are in the same rural health network.

(e) Written policies in RPCHs.—The requirements for written policies and procedures and the supervision of those procedures in rural primary care hospitals would be amended to clarify that the requirements are similar to those for hospitals. Specifically, rural primary care hospitals would be required to appoint a physician, as defined in section 1861(r)(1) of the Social Security Act, to supervise the implementation of the policies.

(f) Limit on inpatient beds in RPCHs.—A rural primary care hospital that had a swing-bed agreement at the time of designation would be authorized to provide swing-bed services up to the hospital's licensed acute care bed capacity at the time of conversion, minus the number of inpatient beds retained by the rural primary care hospital.

(g) Limit on length of stay in RPCHs.—The length of stay requirement for State designation of rural primary care hospitals would be modified to provide that no patient could be admitted unless the attending physician certifies that the patient could reasonably be expected to be discharged or transferred within 72 hours, and that the facility may not provide surgery or other services requiring general anesthesia (other than procedures approved for performance on an ambulatory basis) unless the attending physician certifies that the risk of transfer to another facility for the services outweighs the benefits. The Secretary would be authorized to terminate the designation of a rural primary care hospital whose average length of stay (not counting longer stays during periods of inclement weather or other emergencies) exceeds 72 hours. The General Accounting Office would report to the Congress, within two years after enactment, on the application and impact of the changes in length-of-stay requirements.

(h) Application of cost-sharing requirements.—The applicability of the inpatient hospital deductible and coinsurance to stays in rural primary care hospitals would be clarified.

(i) Payment for outpatient services.—The Secretary would be required to implement a prospective payment system for outpatient RPCH services by January 1, 1996. The election of payment alternatives would continue until the Secretary implemented the new

system. Payment for outpatient rural primary care hospital services would be made without regard to lesser-of-cost-or-charges limits. Minor drafting errors would be corrected.

(j) Rural health plan.—The rural health plan established by the State would have to meet requirements established by the Secretary for such plans, including a requirement that rural health networks established under the plan include facilities serving the same geographic market area. The Secretary would be directed to provide technical assistance, if necessary, to assist States in developing a rural health plan.

(k) Payment of EACH.—The automatic eligibility of EACHs for payment as sole community hospitals would sunset as of October 1, 1996. The Prospective Payment Assessment Commission would report to the Congress by September 1, 1995, on the payment adjustments appropriate to the role and responsibilities of EACHs.

Effective Date.—All provisions would be effective upon the date of enactment.

Sec. 14. Community Health Network Grant Program

Present Law.—(a) Grants to State and local governments.—No provision.

(b) Designation of facilities.—No provision.

(c) Grants to hospitals and facilities.—No provision.

(d) Availability of funds.—No provision.

Explanation of Provision.—In general, a Community Health Network grant program would be created to facilitate the organization and delivery of primary, preventive, and acute care services, including emergency care, for medically underserved populations by fostering community provider networks.

(a) Grants to State and local governments.—The Secretary would award grants to States and local governments. Such Grants would be used for activities related to planning and implementing community health networks.

To be eligible for a grant, a State or local government would be required to prepare a community health plan designed to create community health networks, promote integration of health services, and improve access to hospital and other services. The State or local government would be required to designate non-profit or public hospitals and facilities within community health networks.

A State would be required to consider local input in developing a State plan, and the State plan would be required to address the needs of all underserved communities in the State. In the case of a State that develops a community health plan after a unit of local government has been awarded a Federal grant, the State would be required to take into account the local government plan in developing the State plan.

When a State and a unit of local government within the State both seek a Federal grant, the local government community health plan would be required to be approved by the State. This requirement would not apply in the case of a local government in a State that is not seeking a Federal grant, or in a State that develops a community health plan after a unit of local government has been awarded a Federal grant.

(b) Designation of facilities.—Facilities eligible for designation as a community health network provider for the purpose of the grant program would include facilities that are members or are in the process of becoming members of a community health network, and in the case of hospitals: would qualify for a Medicare disproportionate share adjustment under section 1886(d)(5)(F) of the Social Security Act; are rural referral centers; or are sole community hospitals located in underserved rural areas; and in the case of primary care centers: are Federally Qualified Health Centers, except that the governance requirements need not be met with respect to membership of the Board of Directors if the facility provides assurances of significant consumer input, or are rural health clinics. Other facilities that are members of a community health network would also be eligible for designation. Hospitals that would qualify for a Medicare disproportionate share adjustment as specified would include hospitals that do not currently qualify because they are not hospitals paid under Medicare's prospective payment system.

A community health network would be defined as a public or nonprofit entity which would provide primary care and acute care services to medically underserved populations in the entity's service area, including health promotion, health maintenance, and disease prevention. The network would have to substantially provide these services directly or through limited contracting with non-network providers. The network would be required to consist of at least one hospital and at least three primary care centers.

At the election of the network members, any other entity that provides primary care or other health care services to the medically underserved populations served by the network could be a member of the network. To be considered a community health network, each member hospital would be required to provide staff privileges to physicians providing care at primary care centers, and each member would be required to provide appropriate emergency and medical support services to other members, to accept referrals from other members, and to share in the same communication systems, including, where appropriate, the electronic sharing of patient data, medical records, and billing services.

(c) Grants to hospitals and facilities.—A hospital or facility would be eligible to receive a grant if the hospital or facility is located in a State or locality with an approved community health plan, is designated as a community health network provider by the State in which it is located, and is a member of a community health network. Grants could be used for the development or expansion of primary care sites, development of information, billing and reporting systems, or health promotion, health maintenance, disease prevention, and outreach to underserved populations. Outreach activities could include the training and support of individuals residing in the community as health advisors.

Hospitals and facilities would be required to receive certification by the State in which the facility is located that the receiving of such grant by the hospital or facility is consistent with the State's or locality's community health plan, and that the State has approved the application.

A consortium of hospitals and facilities, each of which is part of the same community health network, is eligible to receive a grant if each of its members would be individually eligible to receive a grant.

Grants to hospitals, facilities, and consortia would be used to finance the costs incurred in planning, implementing and joining community health networks, including costs related to the development of primary care service sites, the development of information, billing and reporting systems, planning and needs assessment, recruitment and training of health professionals and administrative staff, and health promotion outreach to underserved populations in the service area.

A grant made to a hospital or facility could not exceed \$200,000, and the total amount of a grant paid to a consortia of hospitals and facilities could not exceed \$1 million.

(d) Availability of funds.—Funding of \$160 million per year for each of the fiscal years 1996 through 1999 would be made available by the Secretary for the Community Health Network grant program. \$80 million would be payable from the Federal Hospital Insurance Trust Fund for grants to hospitals for the purpose of becoming a part of a community health network. \$80 million would be payable for grants to primary care centers for the purpose of becoming a part of a community health network, from the Capital Financing Trust Fund established under this Title.

Effective Date.—Effective October 1, 1995.

Sec. 15. Capital Financing Assistance

Present Law.—(a) Eligibility for assistance.—No provision.

(b) Capital financing trust fund.—No provision.

(c) Loan guarantees.—No provision.

(d) Interest subsidies.—No provision.

(e) Direct matching loans.—No provision.

(f) Direct grants.—No provision.

(g) Transitional assistance for certain academic health centers.—No provision.

(h) Transfer and allocation of funds.—No provision.

Explanation of Provision.—The Secretary of HHS would provide capital financing assistance to eligible facilities in the form of loan guarantees, interest rate subsidies, direct matching loans, and (in cases of urgent life and safety needs) direct grants.

(a) Eligibility for assistance.—Eligible hospitals include Essential Access Community Hospitals, Rural Primary Care Hospitals, and hospitals that would qualify for Medicare disproportionate share payments under section 1886(D)(5)(F)(vii)(I) with a disproportionate share patient percentage of 40 percent or more, except that investor-owned facilities would not be eligible. Hospitals that would qualify for a Medicare disproportionate share adjustment as specified include hospitals that do not currently qualify because they are not hospitals paid under Medicare's prospective payment system. Primary care centers that are not-for-profit and designated as community health network providers under this Title would also be eligible for capital financing assistance.

Applications filed with the Secretary would be required to have been determined by the State in which the project is located to be

consistent with any relevant community health plan developed as part of the Community Health Network grant program or rural health care plan under the Essential Access Community Hospital program.

In the case of a State determined by the Secretary to have a plan and process for review and approval of capital expenditures, the application would be required to be determined by the State to be consistent with the State capital expenditure plan.

The Secretary would give preference to assistance needed to bring a facility into compliance with Federal, State or local regulatory standards, improve the provision of essential services, or provide access to otherwise unavailable essential health services.

Preference would also be given to projects that include non-Federal assurances of financial support, those that would be unlikely to be financed without assistance, and to projects involving community health network providers designated under this Title. Any health care facility accepting capital financing under this section would agree to provide a significant volume of services to persons not eligible for benefits under this Act.

(b) Capital financing trust fund.—A Capital Financing Trust Fund would be created to finance capital assistance and would be administered by the Secretary of HHS. A Capital Financing Trust Fund Board would be created to advise the Secretary on the program and would meet quarterly. The Board would be composed of the Secretary, the Secretary of the Treasury, the Assistant Secretary for Health, the Administrator of the Health Care Financing Administration, and 5 public members appointed by the President to serve 4-year terms.

The Board would be responsible for approving regulations, establishing program criteria, and recommending and approving expenditures by the Secretary under the Program.

(c) Loan guarantees.—Loan guarantees would be available to qualified health care facilities for repayment of loans to non-Federal lenders making loans for health care facility replacement, modernization and renovation projects, and capital acquisitions.

Up to \$150 million would be annually allocated within the Trust Fund to finance loan guarantees. At least ten percent of the dollar value of the loan guarantees would be allocated for eligible rural health care facilities, to the extent a sufficient number of applications are made. No more than 20 percent of the amount allocated each year to the loan guarantee program would be available to guarantee refinancing of loans during that year.

Facilities seeking a Federal loan guarantee would be required to demonstrate that the guarantee is essential to obtaining financing from non-Federal lenders at a reasonably affordable rate of interest. Facilities would be further required to demonstrate an ability to meet debt service, assume the public service responsibilities, operate the facility in accordance with a management plan approved by the Trust Fund Board, and demonstrate the continuation of any State or local support.

The principal amount of any guaranteed loan could not exceed 95 percent of the total cost of the project, including land, and the Trust Fund Board would be able to institute additional terms and conditions.

The Trust Fund Board would determine a reasonable loan insurance premium to be charged for loan guarantees and would be authorized to collect sufficient amounts to cover the costs of appraisals and inspections of the property. The Board could waive the premium for financially distressed facilities.

The Board would be authorized to pursue to final collection all claims assigned and transferred to the Trust Fund as a result of any property secured by any defaulted loans.

(d) Interest subsidies.—Interest subsidies would be available to reduce the cost of financing qualifying projects by providing partial Federal subsidy of debt service payments.

Up to \$220 million in interest rate subsidies would be made available annually. At least ten percent of the total value of the interest subsidies awarded in any given year would be awarded to rural health care facilities, provided that a sufficient number of applications are approved, with any one State limited to receive no more than 25 percent of the total value of all interest subsidies made during that year.

Interest subsidies would be made in the amount of three percentage points for qualifying non-Federal loans, and interest subsidy grants in an amount of up to five percentage points would be made for qualifying Federal loans made under the program if the project would not be otherwise financially viable.

Subsidies could be provided to assist in refinancing if the health care facility were unable to secure permanent financing at an affordable current market rate. Eligible health care facilities would have had to issue bonds for capital projects, or would have to be obligated to pay debt service on bonds or loans, after December 31, 1992.

No Federal subsidy would be provided unless State or local participation was in an amount at least equal to the amount of the Federal subsidy to be provided.

(e) Direct matching loans.—Direct matching loans would be made available to eligible facilities otherwise unable to obtain financing.

Financing would be for the purpose of essential facility development, replacement (either construction or acquisition), modernization, and renovation.

Direct matching loans would be provided primarily for smaller projects where the transaction costs of securing financing from other sources might be disproportionately onerous in relationship to the amount financed. Not more than 75 percent of the total cost of a project could come from Federal sources, except in instances the Trust Fund Board waives the requirement for financially distressed health care facilities.

Up to \$200 million in direct matching loans would be made available annually, with priority given to projects designed to achieve compliance with governmental regulatory standards. Eligible applicants could receive a project loan of up to \$50 million. Not less than ten percent of the total value of the loans made under the program would be made to rural health care facilities, provided that a sufficient number of applications are approved.

The interest rate would be a market rate determined by the Trust Fund Board to be no higher than the most recent applicable

index for revenue bonds. Loans would be made for a period equal to the construction period plus up to 39 years.

Loans for refinancing could be granted, although the total amount of assistance provided for refinancing could not exceed 20 percent of the total amount made available for direct matching loans in the year.

Prior to beginning collection proceedings in the case of a default of a loan, the Trust Fund Board could attempt to negotiate a revised repayment schedule to avoid foreclosing on property services by such loan.

(f) Direct grants.—Direct grants would be made available to eligible facilities for urgent capital needs. Direct grants would be available for three types of projects only: (i) health care facilities threatened with closure or loss of accreditation or certification as a result of life or safety code violations or similar facility or equipment failures; (ii) health care facilities requiring renovation, expansion, or replacement necessary to the development, maintenance, or expansion of essential safety and health services such as obstetrics, perinatal, emergency and trauma, primary care and preventive health services; and (iii) health care facilities requiring pre-approval assistance to meet regulatory requirements, in the form of planning grants to be used to apply for other assistance. Priority would be given to financially distressed health care facilities as defined by the Secretary.

Up to \$400 million in grants for capital expenditures would be made available annually. Assistance would be limited to \$25 million per eligible health care facility. At least half of the projects funded in a year would be required to receive 50 percent of their funding from state or local sources, with the remaining projects eligible for a combination of Federal grants and loans equal to 90 percent of total funding. Not less than ten percent of the grant funds would be reserved for rural health care facilities, provided that a sufficient number of applications are approved.

Applicants who can demonstrate general qualifications for a direct matching loan or loan guarantee would be eligible for a grant of up to \$200,000 to assist in implementation of key budgetary and financial systems. Up to \$10 million in grants for this purpose would be made available annually.

Adjustments would be made to the level of reimbursement under the Medicare program where appropriate to take into account the extent to which capital-related costs incurred by a hospital are costs with respect to which the hospital received financial assistance under this legislation.

(g) Transitional assistance for certain academic health centers.—The Secretary would provide transitional capital financing assistance to certain academic health centers with major facility replacement projects. Eligible facilities would receive assistance in the form of interest subsidies of up to three percentage points for debt amounts not to exceed 65 percent of the total project cost.

Facilities eligible for assistance would be those that (1) receive direct medical education payments under section 1886(h) of the Social Security Act, (2) qualified as of June 1, 1994 for disproportionate share payments under section 1886(d)(5)(F)(vii)(I) of the Social Security Act, (3) have received approval for a facility replacement

project prior to June 1, 1994 from an applicable State capital approval agency, or in the case of a hospital in a State without such a program, have received approval for the project by the hospital board of directors prior to June 1, 1994, (4) demonstrate that the replacement facility would be placed in patient service by December 31, 2002, (5) have a total replacement project cost of at least \$500 million; and, (6) are a public or not-for-profit hospital.

The Secretary would make \$50 million a year available for projects that qualify under this provision.

(h) *Transfer and allocation of funds.*—Beginning in fiscal year 1996 and through fiscal year 1999, the Secretary of the Treasury would transfer into the Trust Fund on a periodic basis, amounts from general revenue necessary to fund the loan guarantees, interest subsidies, direct matching loans, and direct grants awarded by the Secretary of HHS under this Title, and to provide for payments to primary care centers under the Community Health Network program. Repayments of loans made by hospitals and facilities would be allocated to the Trust Fund.

Effective Date.—Effective October 1, 1995.

Subtitle D. Lead paint abatement

Sec. 16. Lead Paint Abatement Program

Present Law.—No provision.

Explanation of Provision.—The Secretary would establish a comprehensive program to correct lead paint health hazards that would not otherwise be addressed through Federal, State, local, or private measures. In carrying out the purposes of this program, the Secretary would contract with State and local governments. The aggregate annual amount of such contracts would be equal to the funds available in the Lead Paint Abatement Account in the Healthcare Trust Fund established in Title XI.

Contracts would provide for agreements to carry out the following activities: assessing lead paint health risks in the community, inspections and abatement activities carried out by certified contractors, monitoring blood-lead levels of abatement workers, testing effectiveness of abatement activities, training of public employees and nonprofit abatement contractors, relocation and temporary housing for families during abatement, and emergency measures to address conditions that cause immediate exposure.

In establishing this program, the Secretary would allocate funds from the Account under a formula reflecting State or local needs, based on measures of poverty and lead paint health hazards. The formula used to allocate funds to a State or local government would be computed based on the sum of three percentages: (i) the number of young children in poverty that live in the jurisdiction expressed as a percent of all such children nationally; (ii) the number of families in poverty that live in pre-1950 homes in the jurisdiction expressed as a percentage of such families nationally; and (iii) the percent of families in poverty living in pre-1960 homes in the jurisdiction expressed as a percent of such families nationally. To determine the share of the Account allocated to each jurisdiction, these percentages are summed, divided by three and the result is multiplied by the total funds available in the Account.

The Secretary would contract with States, urban counties, cities with populations over 100,000 and consortia of smaller communities. Entities seeking to enter into such contracts with the Secretary would be required to provide assurances that they have the capacity to carry out the program effectively and would provide 10 percent matching funds.

Effective Date.—Effective January 1, 1996.

Subtitle E. Federal grants for managed care plans

Sec. 17. Federal Grants for Managed Care Plans

Present Law.—No provision.

Explanation of Provision.—A program of Federal grants would be established to support the development and initial operation of staff and group-model Health Maintenance Organizations in areas designated by the Secretary as health professional shortage areas, and to support the development of managed care plans in rural areas.

Authorization for appropriations of \$35 million per year for the grant program would be provided fiscal years 1995 through 1999.

The Secretary would award grants to public or non-profit organizations, based on standards and procedures for application established by the Secretary. In awarding grants, the Secretary must be satisfied that sufficient planning has been conducted by the applicant and the feasibility of establishing and operating the organization has been demonstrated by the applicant.

Grants would be awarded for a period of one year, but could be renewed for up to two additional periods of one year each.

Funds would be used for purposes specified by the Secretary, which would include conducting market surveys, activities related to the initial enrollment of individuals, working capital during the startup period, recruitment of physicians and other health personnel, and acquisition of buildings and equipment, and with the development of rural provider networks.

Effective Date.—Effective upon the date of enactment.

Subtitle F. Emergency medical services in rural areas

Sec. 18. Rural Emergency Services Support

Present Law.—No provision.

Explanation of Provision.—The Secretary would be required to establish an Office of Rural Emergency Medical Services within the Department of Health and Human Services. The Office would conduct research, training, evaluation and demonstration projects to foster the development of emergency medical services in rural areas.

The Secretary would be authorized to make grants to States to improve the availability of rural emergency medical services through the support of State offices of rural emergency services. A State receiving a grant would be required to coordinate rural emergency medical services and provide technical assistance regarding Federal and State emergency medical services programs available to serve rural areas. Grants would be approved for a three-year period, with States required to provide matching funds. The Office of

Rural Emergency Medical Services would provide technical assistance to States for the development of State offices of rural emergency services and State rural emergency medical services programs. Authorization of appropriations of \$3 million a year for fiscal years 1996 through 2000 would be provided for State grants.

The Secretary would be further authorized to make grants to States to assist States in the creation or enhancement of air medical transport systems that provide victims of medical emergencies in rural areas with access to treatment for injuries or other conditions resulting from such emergencies. Authorization of appropriations of \$15 million for fiscal year 1996 would be provided for such grants, and such sums as may be necessary for fiscal years 1997 through 2000.

Subtitle G. Biomedical research program account

Sec. 19. Biomedical Research Program

Present Law.—No provision.

Explanation of Provision.—The Secretary of HHS would make funds from the Biomedical Research Account in the Healthcare Trust Fund, established in Title XI, available to support biomedical research. The amounts of support provided for such research each year would be equal to the amount deposited into the Account during that year. Entities eligible to receive these funds would include medical schools, academic health centers, other entities with expertise in biomedical research, and such entities as are eligible to receive grants from the National Institutes of Health (NIH). The Secretary of HHS would establish priorities for the distribution of such funds.

Effective Date.—Effective January 1, 1996.

Subtitle H. United States-Mexico Border Health Commission

Sec. 20. United States-Mexico Border Health Commission

Present Law.—No provision.

Explanation of Provision.—The President would be authorized to conclude an agreement with Mexico to establish a United States-Mexico Border Health Commission. The purposes of this Commission would be to conduct a comprehensive needs assessment in the border area to identify, evaluate, prevent, and resolve health care problems that affect the general population of the area.

Effective Date.—Effective upon the date of enactment.

Title VIII. Medicare and Medicaid

Subtitle A. Medicare part C

Sec. 1. Establishment of Medicare Part C and Other Programs

Present Law.—In general, there is no Federal health insurance program for non-elderly individuals who are not otherwise covered under a private health plan. The Medicare program is restricted to individuals ages 65 and older, individuals receiving social security cash benefits on the basis of disability, and individuals who have end-stage renal disease (ESRD).

The Medicaid program is a joint Federal-State means-tested entitlement program that pays for medical services on behalf of certain groups of low-income persons. However, only 47 percent of persons below the Federal poverty level received Medicaid benefits at any time during 1992. Other Federal health programs are confined to special groups, such as Federal employees, military personnel and dependents, or veterans.

Explanation of Provision.—The Secretary would establish and operate: (i) a Federal health insurance program that would be called Medicare Part C; (ii) a program of premium subsidies for low-income individuals enrolled in Medicare Part C or private qualified health plans; (iii) a program of supplemental benefits for low-income individuals; and (iv) payments for emergency services for certain aliens.

Effective Date.—Medicare Part C and programs for low-income premiums subsidies and supplemental benefits would be effective for items and services provided on or after January 1, 1998.

Sec. 2. Medicare Part C Eligibility and Enrollment

Present Law.—(a) Eligibility.—(i) Eligibility to enroll for health insurance benefits.—No Provision.

(ii) Ineligible individuals.—No provision.

(b) Enrollment.—No provision.

Explanation of Provision.—(a) Eligibility.—(i) Eligibility to enroll for health insurance benefits.—An individual eligible to enroll in Medicare Part C would be defined to include any eligible individual who meets any one of the following requirements: (1) the individual is a part-time, seasonal or temporary employee; (2) the individual is a full-time employee of an employer with 100 or fewer employees, and the employer elects to cover employees under Medicare Part C, rather than under a qualified health plan; (3) the individual is not an employee; (4) the individual is an AFDC or SSI recipient, including SSI 1619(b) status individuals; or (5) the individual is not an employee of a firm with 100 or fewer employees and has income below the percentage of the low-income threshold specified in Title II.

In general, an eligible individual would not be considered eligible for enrollment in Medicare Part C if such an individual is (i) enrolled in a qualified health plan, or (ii) entitled to benefits under Medicare Part A.

When calculating income for the purpose of determining eligibility for Medicare Part C, premium subsidies and wrap-around benefits, a child in State-supervised care would be considered as a unit of one. A child in State-supervised care whose income is less than the threshold amount (specified in Title II) would be eligible for Medicare Part C, premium subsidies and wrap-around benefits.

(ii) Ineligible individuals.—The term “Medicare Part C eligible individual” would not include: (1) an individual who is covered under a qualified health plan; (2) an individual who is entitled to benefits under Medicare Part A, unless Part C would otherwise constitute the primary plan; or (3) an individual whose principal place of abode is in Puerto Rico, the Virgin Islands, Guam, American Samoa, or the Northern Mariana Islands, unless (and so long as) that possession meets certain requirements.

In order for any one possession to meet these requirements, there must be an agreement in effect between the United States and that possession. The agreement must provide that several conditions will be met by the possession, and the possession must in fact comply with those conditions.

In particular, the agreement would provide that the laws of the possession generally will impose on its residents a tax equivalent to the tax imposed under section 59B of the Internal Revenue Code (and any tax subsequently enacted in the United States for the purpose of collecting the individual share of premiums for Medicare Part C benefits). (This tax to be imposed by the possession is referred to in this Committee Report as the possession's Medicare Part C premium individual share tax.) Further, the agreement would provide that nothing in any provision of law, including the law of the possession, will permit the possession to reduce or remit in any way, directly or indirectly, any liability to the possession by reason of the possession's Medicare Part C premium individual share tax.

The agreement would also provide that any amount received in the possession's treasury by reason of its Medicare part C premium individual share tax will be paid (at such time and in such manner as the Secretary of the Treasury shall prescribe) to the U.S. Treasury for credit to the Medicare Part C Trust Fund. Finally, the agreement would provide that the possession must comply with such other requirements as the Secretary and the Secretary of the Treasury deem necessary to carry out the purposes of the provision, including requirements prescribing the information that must be furnished to the Secretary and the Secretary of the Treasury by individuals to whom the possession's Medicare Part C individual tax may apply. The possession and the United States would coordinate their taxes, pursuant to the agreement, so that the two jurisdictions would avoid charging the same individual for Medicare Part C premiums for the same periods.

The Committee intends that each possession bear the burden of establishing to the satisfaction of the Secretary and the Secretary of the Treasury that it has complied, and continues to comply, with the terms of the agreement.

(b) Enrollment.—The Secretary, through the Health Care Financing Administration, the Social Security Administration, and other appropriate agencies would establish a process for determining whether individuals are eligible for Medicare Part C, and for enrollment of eligible individuals.

An eligible individual would be permitted to enroll in Medicare Part C at any time beginning July 1, 1997, with coverage beginning on January 1, 1998. A continuous enrollment period would be provided for individuals whose coverage under a private health plan is terminated. Individuals who enroll after January 1, 1998, would be covered as of the date of enrollment, or another date as the Secretary may specify to assure continuous coverage.

Enrollment under Medicare Part C would be deemed for certain individuals. The Secretary would provide a process under which an eligible individual whose enrollment under a private qualified health plan is terminated, and who is not otherwise covered under another private qualified health plan, would be deemed enrolled as

of the date of termination of coverage. In addition, the Secretary would provide that an individual born in the United States who is not enrolled or otherwise covered under a private qualified health plan at the time of birth would be deemed to have been enrolled under Medicare Part C at the time of birth.

The Secretary would establish procedures to facilitate enrollment, and would coordinate with existing programs and agencies to streamline the enrollment process. In accordance with regulations promulgated by the Secretary, hospitals, rural primary care hospitals, Federally Qualified Health Centers, and any other health center or clinic receiving Federal funds would be required to make applications for Medicare Part C available to individuals, and would assist in the process of enrollment for individuals without a valid health security card. Such hospitals, centers or clinics would have access to information pertaining to the source of health insurance coverage through the enrollment verification system. Such hospitals, centers or clinics would be required to report to the Secretary information to assist in the enrollment and coverage of individuals under Medicare Part C. Upon verification that the individual is not otherwise covered under a private health plan, the Secretary would issue a health security card.

The Secretary would establish outreach programs to ensure full participation of all Medicare Part C eligible individuals who are not otherwise enrolled in a qualified health plan.

The Secretary would make applications for enrollment in Medicare Part C widely available. Applications could be filed with the Secretary by mail, or at such locations as the Secretary specifies.

Effective Date.—Effective for items and services provided on or after January 1, 1998.

Sec. 3. Benefits and Payments

Present Law.—(a) Benefits.—No provision.

(b) Payments to providers.—No provision.

Explanation of Provision.—(a) Benefits.—Benefits that are covered under the guaranteed national benefit package, defined in title III of this Act, would be covered under Medicare Part C.

An individual enrolled in Medicare Part C would be entitled to coverage for any item or service covered under the guaranteed national benefit package, provided the individual or entity furnishing the item or service would be eligible to receive payment for the item or service under Medicare Parts A or B.

(b) Payments to providers.—Payments for services covered under Medicare Part C would be consistent with the payment rates and policies specified under Medicare Parts A and B, with appropriate adjustment in payment amounts to reflect the population served by Medicare Part C.

In the case of any service for which there is not a payment basis under the current Medicare program, the Secretary would establish payment rules that are similar to the payment rules for similar services under the current Medicare program, in consultation with the Prospective Payment Assessment Commission (ProPAC), and the Physician Payment Review Commission (PhysPRC).

The Secretary would establish standardized amounts for inpatient hospital services under Part C, by adjusting the Part A stand-

ardized amount to reflect differences in the average cost of treating enrollees under Medicare Part A and Medicare Part C. The Secretary would be authorized to develop separate DRG categories and weights to reflect resource needs of the Medicare Part C population. Other services currently covered under Medicare Part A would be reimbursed in a manner that is consistent with Medicare payment policies.

By January 1, 1997, the Secretary would be required to develop and implement prospective payment methodologies for services for which a prospective payment system is not used under Medicare Parts A and B. The Secretary would be directed to ensure that payments under such new methodologies would not exceed payments that would otherwise be made for such services under existing payment policies. Such methodologies would be used for payments under Medicare parts A and B and, when implemented, for payments under Medicare part C.

With respect to payments for the classes of hospitals currently exempt from the inpatient hospital prospective payment system, the Secretary would be required to develop prospective payment methodologies by January 1, 1997, for such classes of hospitals where appropriate. Any prospective payment methodology for these hospitals would provide for payment rates based on the resource requirements of such hospitals, determined using data specific to the class of hospitals. The Committee recognizes that the development of prospective payment systems may be possible by that date for some types of hospitals, but not for others. For example, prospective payment for rehabilitation facilities may be developed sooner than prospective payment for other hospitals due to the progress of research in establishing appropriate case-mix measurement systems.

Physician services would be reimbursed using the resource-based relative value scale (RB RVS). In the case of services for which relative value units have not been established, the Secretary would establish relative value units in the same manner as if payments for such services were made under Part B of the current Medicare program.

Payment amounts for services (other than prescription drugs) not currently covered under either Part A or Part B would be established by the Secretary, in consultation with ProPAC and PhysPRC.

Payments for prescription drugs would be determined as described in the specifications of the prescription drug benefit (Title III).

The Secretary would make necessary changes to the adjusted average per capita cost (AAPCC) for purposes of making payments to HMOs with risk contracts to take into account differences between the population served under Medicare Parts A and B, and the population that would enroll under Medicare Part C. In addition, in the case of HMOs with risk contracts under Medicare, the HMO would not be permitted to require physician referral for obstetrics and gynecology.

Beginning January 1, 2001, Medicare Part C would be required to make payments to providers for emergency care services provided to ineligible aliens. For the purpose of this provision, emer-

gency care services would be consistent with the definition that applies currently under section 1867(e)(1) of the Social Security Act.

Effective Date.—Effective for items and services furnished on or after January 1, 1998, other than the provision pertaining to emergency services to ineligible aliens which would be effective for items or services furnished on or after January 1, 2001.

Sec. 4. Premiums and Establishment of Medicare Part C Trust Fund

Present Law.—(a) Premiums.—No provision.

(b) Medicare Part C Trust Fund.—No provision.

Explanation of Provision.—(a) Premiums.—The Secretary would establish three premium structures: individual, single parent, and family coverage. The Secretary would compute a national Medicare Part C premium, and premiums for each State, commonwealth and territory. The premium would be set to cover the full actuarial cost of benefits covered under the guaranteed national benefit package, plus all administrative costs. The premium for 1998 would be set in statute, but if necessary, would be modified by the Secretary to assure that premiums cover the full actuarial cost of benefits and all administrative costs.

In determining the premium for Part C for 1998 through 2001, the Secretary would estimate the premium assuming that three quarters of the eligible population would be enrolled in Part C. In determining the actuarial rates, the Secretary would not take into account any expenditures attributable to individuals enrolled in Medicare Part C who are disabled SSI recipients, nor beginning on and after January 1, 2001, any expenditures attributable to the provision of emergency services to undocumented aliens.

The Secretary would publish applicable premiums by September 30th of each year (beginning in 1997) for the succeeding year. The national actuarial rates would be statutorily set for months in 1998 for each class of family enrollment. If the Secretary finds that the statutorily-specified rates for 1998 are greater or less than the actuarial rates computed by the Secretary, the Secretary would adjust the specified rates to reflect the actuarial rates.

(b) Medicare part C trust fund.—A new Medicare Part C Trust Fund would be established. Medicare Part C premiums paid by individuals and employers would be deposited from general revenues into the Trust Fund. The amount of payments made by States to the Secretary under the maintenance-of-effort requirements would be deposited into the Trust Fund.

Additional funds would be appropriated from general revenues to assure that funds in the Medicare Part C Trust Fund are sufficient to make payments provided for by Medicare Part C, and to cover premium certificates provided to low income individuals enrolled in private qualified health plans, wrap-around benefits and, beginning January 1, 2001, to cover expenditures attributable to the provision of emergency services to undocumented aliens. Such sums as necessary would be authorized to be appropriated from the Medicare Part C Trust Fund to cover the costs of administering the program.

Funds from the current Medicare Hospital Insurance Trust Fund and the current Federal Supplementary Medical Insurance Trust Fund could not be commingled with funds from the new Medicare

Part C Trust Fund. The Trustees of the Medicare Hospital Insurance Trust Fund would become Trustees of the new Medicare Part C Trust Fund, and would oversee activities of Medicare Part C Trust Fund.

Effective Date.—Effective for premiums paid and benefits covered on or after January 1, 1998.

Sec. 5. Administrative Provisions

Present Law.—No provision.

Explanation of Provision.—The Secretary, through the Health Security Administration, the Social Security Administration (SSA), and other appropriate agencies, would perform enrollment and eligibility functions necessary to administer the Medicare Part C program. Any reference in law to the Health Care Financing Administration (HCFA) would be deemed to be a reference to the Health Security Administration. The Secretary would establish a process to determine eligibility for Medicare Part C benefits, a process to facilitate enrollment in Medicare Part C, and a process to collect premiums paid directly to the Secretary by individuals who enroll in Medicare Part C.

In general, premiums would be paid to the IRS in a manner specified under Title II of this bill. In addition, the Secretary would establish a process under which individuals enrolled under Medicare Part C could make payments directly to the Secretary. Premiums owed by persons who are self-employed or who do not work would be paid directly to the Secretary, in a manner specified by the Secretary, or to the IRS, in the same manner as estimated income taxes are paid. The Secretary of HHS would report premium amounts collected from individuals to the Secretary of the Treasury, on an annual basis, but not later than January 31st of each year.

The Secretary would have primary responsibility for the operation of the program, and would utilize administrative procedures established by the current Medicare program, including: agreements with hospitals, participating physicians, treatment of Indian health service facilities, carriers and intermediaries, Medicare reimbursement policies, definitions of services and providers, survey and certification systems, quality assurance systems (including utilization review), fraud and abuse provisions, and data requirements to operate Medicare Part C.

Effective Date.—January 1, 1998.

Subtitle B. Benefits for low-income individuals

Sec. 6. Premium Certificate Program for Low-Income Individuals Covered under Qualified Health Plans Offered by Employers

Present Law.—In general, health services for low-income individuals are covered under the Medicaid program. Medicaid is a joint Federal-State, means-tested entitlement program that pays for medical services on behalf of certain categories of low-income persons. A State must cover certain basic services, and may cover additional services if it chooses. Medicaid is administered by the

States with partial Federal funding. Each State designs its own program within Federal guidelines.

Only 47 percent of persons with income below 100 percent of the Federal poverty level received Medicaid benefits at any time during 1992. There are two principal reasons for this: first, many types of applicants must meet income limits that are based on cash welfare standards which are usually well below the poverty level; and second, Medicaid eligibility is subject to categorical restrictions. Medicaid is available only to members of families with children and pregnant women, and to persons who are aged, blind or disabled. Persons not falling into these categories—such as single adults and childless couples—cannot qualify, no matter how low their income is.

(a) Eligibility.—No provision.

(b) Value of premium certificate.—No provision.

(c) Administration of program.—No provision.

Explanation of Provision.—(a) Eligibility.—Low income individuals enrolled under a qualified health plan offered by an employer, other than individuals entitled to benefits under Part A of the current Medicare program or individuals covered under Medicare Part C and entitled to an exemption from or reduction in Medicare Part C premium obligations, would be eligible for premium certificates. For purposes of determining eligibility for premium certificates, premium certificate eligible individuals would generally be defined as: (i) individuals with income of less than 200 percent of the low-income threshold amount (specified in Title II) in 1998, 1999 and 2000, 220 percent of the threshold amount in 2001 and 2002, and 240 percent of the threshold amount in 2003 and thereafter; and (ii) individuals who are AFDC or SSI recipients.

Individuals enrolled in high deductible plans with a medical savings account would not be eligible for a premium certificate or low-income premium subsidy.

(b) Value of premium certificates.—The premium obligation would be zero for individuals with income below the low-income threshold amounts specified in Title II. The threshold amounts are approximately equal to 100 percent of the poverty level. The value of the premium certificate would decrease, on a sliding-scale basis, for individuals with income between the low income threshold amount and, when fully phased-in, 240 percent of the low income threshold amount, so that at 240 percent of the threshold amount, an individual would be required to pay the full individual share of the premium, net of any employer contributions. The premium obligation would be zero for individuals who receive AFDC or SSI benefits for all months in a taxable year, including SSI 1619(b) status individuals.

The value of the premium certificate for low-income individuals would be capped at the lower of (i) the subsidy amount to which the individual would be entitled if enrolled under Medicare Part C, or (ii) the employee obligation under the plan offered by the employer. A low-income worker covered under a plan offered by an employer would be liable for any excess premium amount, if the employee share of the employer-plan premium exceeds the value of the premium subsidy amount.

(c) Administration of program.—A premium assistance program for low income individuals enrolled in private qualified health plans would be established and operated by the Secretary of Health and Human Services. The Secretary would determine eligibility for premium subsidies, and would establish a procedure for payment of such subsidies to plans that enroll subsidy-eligible individuals. Subsidies provided by the Secretary would be applied against the enrollee's obligation for the cost of the premium under a qualified health plan.

An individual enrolled in a employer's private health plan could apply for low-income premium subsidies, by filing an application with a local Social Security Office. Determinations of eligibility would be made on a prospective basis by the Secretary.

The Secretary would require attachments to the application of any documentation needed to determine the individual's eligibility for premium certificates. Such documentation could include prior year tax forms, pay stubs and other information deemed necessary to facilitate determination of eligibility.

Employers would be required to provide employees with documentation of the employee's premium obligation under the employer's plan, in a timely manner, upon request from the employee, consistent with the requirements established under Title II.

The Secretary would provide prompt determination of eligibility on each application for premium certificates, and for prompt notification to individuals who submit an application for such certificates.

Any individual who receives a premium certificate would be required to report any change in status that would affect the value of the certificate provided under this program. During the year, an individual would be required to submit a revised application to reflect changes in the estimated income of the family, including changes in employment status of family members or any other changes that could affect the amount of premium subsidy to which the individual was entitled.

Upon determination that an individual was entitled to a premium certificate, a premium certificate would be issued by the Secretary to an eligible individual. The individual would transfer the certificate to his or her employer, and the employer (or carrier) would make appropriate adjustments in future monthly premium obligations owed by the employee, net of the value of the premium certificate. Any employer that receives a premium-assistance certificate from an employee would submit the certificate to the Secretary for payment of amounts due on behalf of the employee.

The Secretary would provide a direct premium payment to an eligible individual for any premium paid by the individual under the private employer health plan, but only for premiums paid in the month during which the individual filed a complete application.

The Secretary would periodically verify information reported on the premium certificate application, using: (i) the national enrollment verification system established under Title IX of this bill; (ii) information reported by the States administering benefits for AFDC and SSI recipients; (iii) W-2 reported information, maintained by the Social Security Administration; (iv) information, provided, upon request, by the Secretary of the Treasury, including in-

formation returns and other information filed with the IRS; and (v) and other information deemed to be necessary.

If the Secretary determines, based upon tax return and other information, that amounts paid under the premium certificate program exceeded any amounts that should have been provided, the Secretary would bill the individual for the amount of excess premium payments, and would charge interest for any late payments by the individual. If such an individual continued to receive premium certificates administered by the Secretary, the Secretary would adjust the value of future premium certificates by any amount of overpayments.

If the Secretary determines, based upon tax return and other information, that the amounts paid under the premium certificate program were less than the amount to which the individual was entitled, the Secretary would provide a refund to the individual for the amounts owed, net of certificates already provided.

Any individual who knowingly makes a material misrepresentation of information in an application for assistance would be liable for excess payments made based upon such misrepresentation and interest on such excess payments, at a rate specified by the Secretary. In addition, such individuals would be subject to a civil monetary penalty for \$1,000, or, if greater, 3-times the amount of excess payments made based on such misrepresentations.

Effective Date.—Effective for premium obligations for months beginning January 1, 1998.

Sec. 7. Wrap-Around Benefits for Low-Income Individuals

Present Law.—Under the Medicaid program, States must provide acute and long-term care benefits to defined eligible individuals, and have the option of covering others. Each State defines its own package of covered medical services within broad Federal guidelines. Thus, there is considerable variation among the States in types of services covered and the amount of care provided under specific service categories. Medicaid covers a range of acute and long-term care services. Mandatory services include inpatient and outpatient hospital services, nursing facility (NF) services, physician services, laboratory and X-ray services, “early and periodic screening, diagnostic, and treatment services” (EPSDT) for children under age 21, family planning services, home health services, services provided in rural health clinics and federally qualified health centers (FQHCs). Optional services include prescription drugs, dental and optical services, and care in intermediate care facilities for the mentally retarded (ICFs/MR) and in institutions for mental diseases (IMDs).

- (a) Eligibility.—No provision.
- (b) Wrap-around benefits.—No provision.
- (c) Application for benefits.—No provision.
- (d) Determination of eligibility.—No provision.
- (e) Verification of eligibility.—No provision.
- (f) Penalties for misrepresentation.—No provision.

Explanation of Provision.—(a) Eligibility.—An individual, other than an individual entitled to benefits under Medicare Part A, would be considered eligible for wrap-around benefits, provided: (i) the individual is determined to have projected income that is less

than 100 percent of the threshold amount, specified under Title II of this Act, which is generally 100 percent of the Federal poverty level; (ii) the individual is an AFDC or SSI recipient, including SSI 1619(b) status individuals; (iii) the individual is a child under age 19 with projected family income that is less than 200 percent of the threshold amount; or (iv) the individual is a pregnant woman with projected family income that is less than 200 percent of the threshold amount.

Individuals eligible for wrap-around benefits would be able to receive such benefits, if enrolled in Medicare Part C or under a private qualified health plan offered by an employer; however, payment for deductibles and coinsurance would not exceed amounts that would be payable if the individual were enrolled in Medicare Part C.

Individuals enrolled in a high deductible plan with a medical savings account would not be eligible for wrap-around benefits.

(b) Wrap-around benefits.—Deductibles and copayments for all covered items and services would be waived. EPSDT services as defined in Section 1905(r) of the Social Security Act, not otherwise included in the guaranteed national benefit package, would be covered for children to age 19. EPSDT services provided under current law include screening services, vision services, dental services, hearing services, diagnostic services, treatment, and other benefits to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.

Vision and hearing care, including eyeglasses and hearing aids would be covered.

In the case of an individual enrolled in a State managed mental health program, the individual would be considered to have waived the right to mental health benefits provided under the wrap-around benefit package. The Secretary would make a per capita payment to the State on behalf of any wrap-around eligible individual who enrolled in a State managed health care program.

Payments for wrap-around benefits would be paid from the Medicare Part C Trust Fund, and would be based upon payment rules established by the Secretary, in consultation with the Prospective Payment Assessment Commission and the Physician Payment Review Commission. Providers would be compensated by the Medicare Part C Trust Fund, on behalf of individuals determined to be eligible for wrap-around benefits, for Medicare Part C deductibles, copayments or coinsurance.

(c) Application for benefits.—Low-income individuals would apply to the Secretary for coverage of wrap-around, at any time during the year. The application would be in a form and manner specified by the Secretary. The application would require the provision of information with respect to the qualified health plan elected, if other than Medicare Part C, in which the individual is enrolled.

(d) Determination of eligibility.—The Secretary, through the Social Security Administration and other appropriate agencies, would establish a process for determining whether individuals are eligible for wrap-around benefits.

For purposes of determining eligibility, income would be based upon documentation of current and projected family income over a period of at least three months, as determined under uniform na-

tional eligibility criteria established by the Secretary. An asset test would not be used to determine eligibility for benefits.

Individuals who at the time of application are AFDC or SSI cash recipients, would be deemed to be eligible for supplemental benefits under Medicare Part C. Such individuals would be required to report a change in benefit status, with respect to AFDC and SSI benefits. The Secretary would provide for a method under which AFDC or SSI recipients are notified of the wrap-around benefits to which they are entitled.

Benefits would be available with respect to expenses incurred for items and services furnished after the date the individual is determined to be eligible for wrap-around benefits.

In general, individuals determined to be eligible for benefits would remain entitled to wrap-around benefits for a period of twelve months, beginning on the date on which the determination takes effect. Individuals would be required to file an application to extend benefits beyond the twelve-month period. An exception to the limited period of coverage would apply to AFDC or SSI recipients.

Individuals determined to be eligible for wrap-around benefits would be required to provide notice of any change in income or status that would have the effect of making the individual ineligible for wrap-around benefits.

(e) *Verification of eligibility.*—Additional verification of income eligibility would be required, as the Secretary deems appropriate. The Secretary, in consultation with the Secretary of the Treasury, would verify eligibility for supplemental benefits.

On a periodic basis, the Secretary would verify the status of individuals who are receiving wrap-around benefits in order to identify changes of employment or other status that may affect eligibility for benefits. To verify information reported on the application, the Secretary would use the enrollment verification system (established under Title IX of this Act), and other available means, and would require States and entities administering AFDC or SSI benefits to report information that may be necessary to verify an individual's eligibility for benefits, on the basis of being an AFDC or SSI recipient.

If the Secretary determines that, due to a change in income or status, an individual is no longer eligible for wrap-around benefits, the Secretary after notice and opportunity for a hearing, may terminate benefits. An individual would have a right to appeal a denial of benefits, and a right to an explanation for the denial.

(f) *Penalties for misrepresentation.*—Penalties would be imposed for misrepresentation of income. Civil monetary penalties not to exceed \$1,000 for each misrepresentation, or if greater, three-times the amount of the benefits obtained as a result of the misrepresentation would be imposed on individuals who knowingly misrepresent income for the purpose of obtaining benefits to which they are not entitled.

Effective Date.—Wrap-around benefits would be provided as of January 1, 1998.

Sec. 8. Revisions to the Medicaid Program

Present Law.—Medicaid is a joint Federal-State means-tested entitlement program that pays for medical services on behalf of certain groups of low-income persons. States must provide Medicaid acute and long-term care benefits to certain population groups and have the option of covering others. A State must cover certain basic services, and may cover additional services if it chooses.

Explanation of Provision.—A State plan under Medicaid would discontinue coverage for all items and services which would be covered under the guaranteed national benefit package and the wrap-around benefit package, effective January 1, 1998. Such services would no longer be considered medical assistance for purposes of Federal financial participation. This rule would apply to all Medicaid beneficiaries who are eligible individuals, as defined in Title I, but would exclude Medicaid beneficiaries who are eligible for Medicaid but covered only for emergency services because they are undocumented persons. The current law requirement that States provide emergency services to undocumented aliens through the Medicaid program would be repealed, effective January 1, 2001.

Medicaid coverage of acute-care services would be repealed, effective upon the operation of the Medicare Part C program. A State plan under Medicaid would continue to provide coverage to individuals eligible for both Medicare and Medicaid who exceed the limits under Medicare for inpatient mental health services. In addition, Medicaid would continue to cover long-term care, and other institutional services, including services for the mentally retarded and services provided in nursing facilities. State Medicaid payments for such mental health, long-term care and other institutional services would continue to be subject to the current Federal matching assistance percentage (FMAP).

Effective Date.—Effective for items or services furnished on or after January 1, 1998.

Sec. 9. Federal Payment for Medicare Cost-Sharing for Qualified Medicare Beneficiaries

Present Law.—Medicaid provides partial coverage for low income Medicare beneficiaries, known as Qualified Medicare Beneficiaries (QMBs). A QMB is an aged or disabled Medicare beneficiary whose income is at or below 100 percent of poverty, and whose resources are at or below 200 percent of the SSI limit (\$4,000 for an individual and \$6,000 for a couple). Medicaid is required to pay Medicare premiums and cost-sharing for these persons. Medicaid protection is limited to payments of these charges, unless the beneficiary is otherwise eligible for benefits under the program. Since 1993, States have been required to pay Medicare Part B premiums, but not cost-sharing, for Medicare beneficiaries with income up to 110 percent of the Federal poverty line. This limit rises to 120 percent of the Federal poverty line, beginning in 1995.

Explanation of Provision.—States would no longer be required to pay Medicare Parts A or B premiums and cost-sharing obligations for Qualified Medicare Beneficiaries (QMBs), nor Medicare premiums for low-income Medicare beneficiaries with income up to 120 percent of the Federal poverty level. Payments on behalf of

such low income Medicare beneficiaries would be paid by the Federal government.

Effective Date.—Effective for items and services furnished on or after January 1, 1998.

Sec. 10. State Maintenance-of-Effort

Present Law.—(a) Continuation of Medicaid coverage.—Medicaid is a joint Federal-State means-tested entitlement program that pays for medical services on behalf of certain groups of low-income persons. States must provide Medicaid acute and long-term care benefits to certain population groups and have the option of covering others. A State must cover certain basic services, and may cover additional services if it chooses. Medicaid is administered by the States with partial Federal funding. Each State designs its own program within Federal guidelines.

The cost of the Medicaid program is shared between the States and the Federal government. The Federal governments share of the cost is known as the Federal medical assistance percentage (FMAP). The FMAP may vary between 50 percent and 83 percent, based on a formula designed to provide a higher Federal share for States with lower per capita incomes. The FMAP for each State is determined annually. In 1993, the highest FMAP was for West Virginia (76.29), while twelve States had the minimum FMAP (50.00).

Medicaid beneficiaries generally fall into one of two categories: (i) cash recipients who are individuals receiving cash welfare benefits under either the Aid to Families with Dependent Children (AFDC) program or the Supplemental Security Income (SSI) program and (ii) other individuals eligible under Federal guidelines for whom there is Federal financial participation for incurred health care costs.

Each State defines its own package of covered medical services within broad Federal guidelines. Thus, there is considerable variation among the States in types of services covered and the amount of care provided under specific service categories. Medicaid covers a range of acute and long-term care services.

Mandatory services include inpatient and outpatient hospital services, Nursing Facility (NF) services, physician services, laboratory and X-ray services, “early and periodic screening, diagnostic, and treatment services” (EPSDT) for children under age 21, family planning services, home health services, services provided in rural health clinics and federally qualified health centers (FQHCs). Optional services include prescribed drugs, dental and optical services, and care in intermediate care facilities for the mentally retarded and in institutions for mental diseases (IMDs). Federal law draws a distinction between mandatory services and optional services.

Under current Medicaid law, States have considerable freedom to develop their own methods and standards for reimbursement of Medicaid services.

(b) State payments for maintenance of effort.—No provision.

(c) Maintenance of effort related to cash recipients.—No provision.

(d) Maintenance of effort related to non-cash recipients.—No provision.

(e) Special rules for Puerto Rico and other territories.—No provision.

(f) Enforcement and Sanctions.—No provision.

Explanation of Provision.—(a) Continuation of Medicaid Coverage.—Except as provided in this bill, Medicaid generally would continue to function as under current law. However after 1998, individuals currently entitled to benefits under Medicaid would receive most acute care benefits under either a private plan, or under Medicare Part C, depending on the plan for which the individual is eligible and elects to enroll.

The Secretary would be prohibited from approving any change in a State's Medicaid program that would take effect prior to the implementation of Medicare Part C and that would substantially reduce a State's obligation under the maintenance of effort provisions that follow.

(b) State maintenance of effort payments to Medicare Part C.—Beginning in 1998 with implementation of Medicare Part C, States would be required to make maintenance-of-effort payments to Medicare Part C. Payments equal to one-twelfth of the Secretary's estimate of the annual obligation would be made each month. Payments would be made in the same manner, and using the same process, as current State "buy-in" payments to Medicare Part B.

The State would periodically provide the Secretary with such information as the Secretary may require to verify the amounts payable. The amount of the payments would be subject to audits by the Secretary. No later than June 30 of each year, the Secretary would provide for a reconciliation of the amounts due under each State's maintenance of effort obligations during the preceding year. Amounts subsequently payable would be adjusted to reflect the results of the reconciliation calculation.

The total amount of the annual maintenance of effort payments would be equal to a percentage of the sum of the cash and non-cash amounts, determined in a manner described in the following sections. The applicable percentage would be 100 percent in 1998, 1999, and 2000, 96 percent in 2001 and 2002, and 86 percent thereafter. Beginning in 2001, an amount equal to one percentage point of the total maintenance of effort payments would be deposited into the Medicare Part C Trust Fund to offset the additional costs of providing emergency care services under Medicare Part C for undocumented aliens.

(c) Maintenance of effort related to cash recipients.—For years after 1997, a State's maintenance of effort payment relating to cash recipients would be equal to the sum of the amounts related to AFDC and SSI.

The AFDC portion would be equal to the product of: (i) the AFDC per capita amount for the year (including amounts related to disproportionate share payments under current law); (ii) the number of AFDC recipients in the State in such year; and (iii) the State medical assistance percentage, defined as one minus the Federal medical assistance percentage (FMAP) for the State as determined for the year under current law.

For each State, the Secretary would determine a 1993 baseline level of State Medicaid expenditures per AFDC beneficiary, including Federal matching payments. These expenditures would include

payments for covered Medicare Part C services (including deductibles and coinsurance amounts and benefits provided under the Federal low-income plan) for services provided to AFDC beneficiaries covered under the State's Medicaid program. These expenditures would be divided into two components. The first would exclude amounts related to disproportionate share hospital (non-DSH) payments made by the Medicaid program; the second would be the amount of payments related to disproportionate share hospital (DSH) payments.

The 1993 AFDC per capita amounts would be updated to the year preceding implementation of Medicare Part C (1997), using the estimated rates of growth in these per capita expenditures between 1993 and 1997.

The 1993 SSI per capita amounts, non-DSH and DSH, would be calculated in the same manner as the AFDC amounts. Each component would be updated to 1997 by their respective baseline rates of growth between 1993 and 1997.

For each year following 1997, the AFDC and SSI per capita amounts (including both the non-DSH and DSH amounts) would be increased by the same percentage as the national Medicare per capita estimate is increased for the year (as determined in Subtitle B of title VIII). Under this provision, the annual increase in the AFDC and SSI amounts would be phased down to the annual per capita growth in the Gross Domestic Product (GDP).

(d) Maintenance of effort related to non-cash recipients.—A State's maintenance of effort payment related to non-cash recipients would be equal to the State's spending in a base year for non-cash beneficiaries (including amount related to disproportionate share payments under current law), updated to the current year.

For each State, the Secretary would determine a 1993 baseline level of State Medicaid expenditures, excluding Federal matching payments, related to payments for services provided to individuals covered under the State's Medicaid program who are not either AFDC or SSI eligible individuals. Expenditures for services provided with respect to individuals covered under Medicaid but for whom there is no Federal matching payment would be excluded from this amount. These expenditures would include all payments for covered Medicare Part C services (including deductibles and coinsurance amounts and benefits provided under the Federal low-income plan) for services provided under the State's Medicaid program. As for the cash recipients, these expenditures would be divided into two components: non-DSH and DSH.

The 1993 non-cash, non-DSH and DSH amounts would be updated to the year preceding implementation of Medicare Part C (1997), using the estimated rates of growth in these expenditures between 1993 and 1997. For subsequent years, both components of the non-cash maintenance of effort would be equal to the amount for the preceding year, increased by the percentage by which the national Medicare per capita estimate is increased for the year (as determined in Subtitle B of title VIII), multiplied by one plus the percentage growth in the general population under age 65.

(e) Special rules for Puerto Rico and other territories.—The maintenance-of-effort payments of Puerto Rico and the other commonwealths and territories related to Medicare Part C related to

cash recipients and non-cash recipients would be determined by using the same computations and requirements applicable to the States.

With respect to maintenance of effort related to cash recipients, for purposes of determining a 1993 baseline level of Medicaid expenditures per AFDC beneficiary including Federal matching payments, the Secretary, in consultation with the commonwealths and territories, would compute what the level of such Medicaid expenditures per AFDC beneficiary would have been in each of such jurisdictions if they had been States for the purposes of calculating such expenditures.

With respect to maintenance of effort related to non-cash recipients, for purposes of determining a 1993 baseline level of Medicaid expenditures excluding Federal matching payments, related to payments for services provided to individuals covered under the jurisdictions' Medicaid program who are not either AFDC or SSI eligible individuals, the Secretary, in consultation with the commonwealths and territories, would compute what the level of such Medicaid expenditures would have been in each of such jurisdictions if they had been States for the purposes of calculating such expenditures.

In general, these amounts would determine the annual maintenance-of-effort payments of the commonwealths and territories relating to Medicare Part C.

However, in determining the maintenance of effort payments, the obligations of the commonwealths and territories determined under this section would be budget neutral to the amount that would be determined under this provision without regard to treating commonwealths and territories as if they were States minus the amount of revenue produced by the application of the tax on tobacco products in Puerto Rico as provided under this bill."

(f) *Enforcement and sanctions.*—In the case of a State that fails to make required payments, the Secretary of HHS would withhold the required amount from Federal matching payments that would otherwise be paid to the State for all programs within the Department. In the case of a State for which the Federal matching payments are not equal to or greater than the State's maintenance of effort obligation, the Secretary of HHS would not make any other payments to the State for any program within the Department. To the extent that payments under programs within the Department are made to individuals (whether or not such payments may be administered by a State agency), the Secretary would continue to make such payments.

Effective Date.—Subsections (a), (e) and (f) would be effective on the date of enactment. Subsections (b), (c), and (d) would be effective in each State no later than January 1, 1998.

In the case of a State for which January 1, 1998 is before the first day of the first year following the close of the first regular session of the State's legislature that begins on or after enactment of this Act, the State would be required to make payments to Medicare Part C equal to 100 percent of the Part C premium on behalf of each individual entitled to Medicaid under the State plan.

Subtitle C. Cost containment in Medicare

Sec. 11. Health Expenditure Estimates for Medicare

Present Law.—(a) Establishment of estimate.—No provision.

(b) Estimate for 1995, the base year.—No provision.

(c) Publication of estimates.—No provision.

(d) Limits on growth in 1996 and subsequent years.—No provision.

(e) Adjustments for additional benefits and savings.—No provision.

Explanation of Provision.—(a) Establishment of estimate.—Beginning for 1996, the Secretary annually would estimate a national Medicare per capita health expenditures estimate. In 1996 and 1997, the estimate would be equal to the national Medicare Part A and Part B per capita estimate for the year. In years after 1997, the estimate would be equal to the average, weighted by the estimated population enrolled in the respective programs, of the national Medicare Part A and Part B per capita estimate and the national Medicare Part C per capita estimate.

In a manner parallel to the private sector estimate, the Medicare per capita estimates would include all payments (including cost sharing) made for the services covered under the Medicare Parts A, B, and C and under the low-income benefit package, including: inpatient and outpatient hospital services; physician services; diagnostic testing services (including laboratory and x-ray services); home health, prescription drugs, biologicals and insulin; Medicare covered nursing facility services, durable medical equipment, orthotics and prosthetics; mental health services (including inpatient and outpatient drug and alcohol treatment); rehabilitation services; and expenditures for services provided in managed care plans.

The estimates would exclude services not covered under Medicare, such as payments: (i) for non-prescription medications; (ii) for institutional long term care services or skilled nursing facilities, and inpatient mental health services of a custodial nature; (iii) payments for personal comfort or convenience items; and (iv) home-maker and home health aide services, and personal care services.

(b) Estimate for 1995, the base year.—The Secretary would compute a baseline national Medicare Part A and Part B per capita estimate for 1993, including all amounts included within the system of estimates. The estimate would be based on actual expenditures under the Medicare program, excluding payments that are excluded from the system of estimates, divided by the number of persons eligible for benefits under Medicare. This amount would be updated to 1995 using the baseline estimate of growth in Medicare expenditures per capita.

The Secretary would estimate a national Medicare Part C per capita estimate for 1998. This amount would be based on the payment rates that would apply under Medicare Part A and Part B in 1998, and would reflect the characteristic of the population expected to enroll in Medicare Part C. The estimate would reflect amounts for all services covered under Medicare Part C, including the low-income benefit package.

In general, the Secretary would not be permitted to adjust the national Medicare Part A and Part B per capita estimate, national Medicare Part C per capita estimate, baseline growth rates or other factors once the initial estimates are established. The Secretary may recommend changes in the estimate, but implementation of such changes would require Congressional action.

The Secretary would be permitted to make certain specified adjustments in the national Medicare Part A and Part B per capita estimate for 1995. Specifically, the estimate for 1995 could be amended by the Secretary to correct errors in the estimation of spending in 1993, and errors in the estimation of the growth in spending between 1993 and 1995, relative to the predicted level.

(c) Publication of estimates.—Beginning in 1995, the Secretary's initial determination of the national Medicare per capita estimates for the following year would be published in the Federal Register by April 1 of each year. The Secretary's final determination of the estimates would be published by October 1 of each year for the following year. In the initial year, the Secretary also would determine and publish the baseline rate of growth in the national Medicare Part A and Part B per capita estimate.

(d) Limits on growth in 1996 and subsequent years.—In general, the national Medicare Part A and Part B per capita estimate, and the national Medicare Part C per capita estimate would be equal to the respective estimate for the preceding year, increased by the sum of one plus the five-year moving average of the annual percentage rate of growth in the per capita gross domestic product (GDP) plus an additional percentage adjustment.

The additional percentage adjustment would be set by statute such that the estimated, baseline rate of growth in the national Medicare per capita estimates would be reduced by two percentage points in 1996, and one additional percentage point each subsequent year, until the limit on the rate of growth is reduced to the rate of growth in the GDP. The additional percentage increase could be changed by subsequent legislation in order to accommodate an unanticipated need for additional health spending. Based on the initial estimate for 1998, the national Medicare Part C per capita estimate would be increased annually by the same percentage as the national Medicare Part A and Part B per capita estimate.

(e) Adjustments for additional benefits and savings.—The national Medicare Part A and Part B per capita estimate and the National Medicare Part C per capita estimate would be adjusted in each year to reflect the additional benefits and savings provided titles III and VIII.

Effective Date.—Effective upon the date of enactment.

Sec. 12. Classes of Health Care Services

Present Law.—(a) Definitions of classes.—No provision.

(b) Recommendations by commissions.—The Prospective Payment Assessment Commission (ProPAC) and the Physician Payment Review Commission (PPRC) are independent commissions that provide annual recommendations to the Congress on issues relating to hospital and physician payments under Medicare, and to issues relating to health care services and financing.

Explanation of Provision.—(a) Definitions of classes.—In a manner consistent with the national private sector per capita estimate, the national Medicare estimates would be divided into separate classes of services. In general, these classes would be identical to the classes established for the private sector estimates under title VI. The classes would initially be specified in the following order: (i) inpatient hospital services (other than mental health services); (ii) outpatient hospital and ambulatory facility services (including renal dialysis and excluding mental health services in such facilities); (iii) diagnostic testing services (including clinical laboratory and x-ray services); (iv) physician and other professional medical services (other than mental health services); (v) home health services; (vi) prescription drugs, biologicals and insulin; (vii) covered nursing facility services; (viii) rehabilitation services including physical, occupational, and speech therapy; (ix) durable medical equipment and supplies; and (x) mental health services. Services which may fall into more than one category are included in the first class in the above list to which they could be classified.

The Secretary could group other items and services into a new class or classes, or a specified class or classes, as may be appropriate.

Items and services excluded from the determination of the Medicare per capita estimate would also be excluded in the definition of the classes of services.

The Secretary would publish a proposed specification of the classes by April 1, 1995, and final specifications by October 1, 1995. The Secretary would include in such publications, the definition of the class or classes to be established, the services within each class, and the methods and sources of data for computing the national private per capita estimate for each class.

Once established, the Secretary would not be permitted to modify or change the classes. The Secretary would periodically submit a report to Congress recommending changes in the classes.

Services not covered under either Medicare or the supplemental plan for low-income individuals would, for the purpose of establishing the Medicare estimate, not be considered to be health services and would not be classified into a class. These items and services would include: (i) over-the-counter medications and medical equipment and devices, not provided pursuant to a prescription; (ii) homemaker and home health aide services and personal care services not otherwise provided in conjunction with home health services; (iii) intermediate care facility services for the mentally retarded; and (iv) inpatient mental health services of a custodial nature.

(b) Recommendations by commissions.—The Prospective Payment Assessment Commission (ProPAC), the Physician Payment Review Commission (PPRC), and the Prescription Drug Payment Review Commission (DrugPRC) established under title III would submit recommendations to the Congress on the initial specification of the classes not later than March 1, 1995. The Commissions would report on the Secretary's proposed classes by June 1, 1993.

Each Commission would make periodic reports to the Congress that may include recommendations of changes in the system of classification as it applies to Medicare.

Effective Date.—Effective upon the date of enactment.

Sec. 13. Allocation of the Medicare Estimates by Class of Service

Present Law.—(a) Allocations by class of service for Medicare part A and part B.—No provision.

(b) Allocations by class of service for Medicare part C.—No provision.

(c) Calculation of the combined allocation for each year.—No provision.

(d) Recommendations by commissions.—ProPAC and PPRC are independent commissions that provide annual recommendations to the Congress on issues relating to hospital and physician payments under Medicare, and to issues relating to health care services and financing.

Explanation of Provision.—(a) Allocations by class of service for Medicare part A and part B.—In general, the national Medicare Part A and Part B per capita estimate would be allocated annually to each class of health services.

The amount allocated to each class, for a year, would be equal to the national Medicare Part A and Part B per capita estimate allocated to the class for the preceding year, increased by the annual Medicare Part A and Part B trend factor for the class. The sum of the allocations so determined for all classes would be adjusted such that the sum was equal to the Medicare Part A and Part B per capita estimate for the year.

The Secretary would, in conjunction with the publication of the national private per capita estimate, publish the allocation of the national Medicare Part A and Part B per capita estimate to each class. The initial allocations for 1996 would be published not later than August 1, 1995.

In order to determine the initial allocation of the Medicare Part A and Part B per capita estimate by class of service, the Secretary would determine a base level of per capita spending within each class, using data based on 1993. In addition, the Secretary would estimate the annual Medicare per capita rate of growth of spending for each class during the five year period ending in 1995.

The allocation of the classes in 1995 would be estimated by increasing the allocations to each class in 1993 to 1995 by the trend factor over the two year period, and then making a uniform adjustment in the allocation to each class such that the sum across all classes would be equal to the national Medicare Part A and Part B per capita estimate in 1995.

The Secretary could not subsequently change the allocations. If the Secretary determined that a change in the allocation of the estimate among classes was appropriate, the Secretary would submit a recommendation to the Congress regarding such a change. Such recommendation would include an explanation of the rationale for such change, and the impact on the allocation of the national Medicare Part A and Part B per capita estimate resulting from such proposed change.

The Secretary would be permitted to make certain specified adjustments in the allocations for 1995, and to the trend factors. Specifically, the estimates for 1995 could be amended by the Secretary to correct errors in the estimation of the allocation of spending in

1993, and errors in the estimation of the growth in per capita spending in each class for the five-year period ending in 1995. If the Secretary made a correction to the estimate for 1995, the Secretary would also make conforming changes to the allocations and estimates for subsequent years.

Consistent with the adjustment to the national Medicare spending estimates, the allocations for Medicare Part A and Part B would be adjusted to reflect implementation of Medicare Part C and the new Medicare benefits and savings provisions as provided in titles III and VIII.

(b) Allocations by class of service for Medicare part C.—In general, the national Medicare Part C per capita estimate would be allocated annually to each class of health services.

For 1998, the Secretary would estimate the allocation of the national Medicare Part C per capita amount among each of the classes, based on the best available data, and consistent with the information and assumptions used in determining the applicable premiums for Medicare Part C.

The amount allocated to each class, for a year after 1998, would be equal to the national Medicare Part C per capita estimate allocated to the class for the preceding year, increased by the annual Medicare Part C trend factor for the class. The sum of the allocations so determined for all classes would be adjusted such that the sum was equal to the Medicare Part C per capita estimate for the year.

The trend factors for each class used in estimating the allocations in future years would be based on the factors estimated for the allocation of the national private per capita estimates, as described in title VI. The Secretary would be permitted to modify these trend factors, based upon data from the Medicaid program and such other data as the Secretary determines to be appropriate.

The Secretary would, in conjunction with the publication of the national private per capita estimate, publish the allocation of the national Medicare Part C per capita estimate to each class. The initial allocations for 1998 would be published not later than April 1, 1997.

The Secretary could not subsequently change the allocations with respect to the national Medicare Part C per capita estimates. If the Secretary determined that a change in the allocation of the estimate among classes was appropriate, the Secretary would submit a recommendation to the Congress regarding such a change. Such recommendation would include an explanation of the rationale for such change, and the impact on the allocation of the national Medicare Part C per capita estimate resulting from such proposed change.

Consistent with the adjustment to the national Medicare spending estimates, the allocations for Medicare Part C would be adjusted to reflect the new Medicare benefits and savings provisions as provided in titles III and VIII.

(c) Calculation of the combined allocation for each year.—For 1996 and 1997, the Secretary would estimate a combined Medicare allocation to each class equal to the allocation of the national Medicare Part A and Part B per capita estimate to each class.

For years after 1997, the Secretary would estimate a combined Medicare allocation equal to the average of the allocations of the national Medicare Part A and Part B per capita estimate and the national Medicare Part C per capita estimate, weighted to reflect the average number of individuals covered under Medicare Parts A and B, and covered under Medicare Part C.

(d) *Recommendations by commissions.*—ProPAC, PPRC, and DrugPRC would review and report to the Congress annually on the allocation of Medicare health expenditures to the different classes of health services. The Commissions would review the effect of the trend factors used in the allocation of the Medicare estimate among classes of services and make recommendations about adjustments in the trend factors to take into account: changes in health care technology; changes in patterns and practices relating to health care delivery found to be appropriate; changes in the distribution of health care services; and special health care needs of underserved rural and inner-city populations.

Each Commission would make periodic reports to the Congress on changes in the system of classification and include appropriate recommendations in such reports.

Effective Date.—Effective upon the date of enactment.

Sec. 14. Updates for Medicare Services

Present Law.—Under current law, Medicare payments for services are updated under a variety of methods. Payments to hospitals are generally updated by the hospital market basket index on October 1 of each year. Limits on payments for hospital services not made under the prospective payment system are generally updated effective with each hospital's fiscal year.

Payments for physician services are updated under the Medicare Volume Performance Standard system on January 1. Other Part B services generally are updated by either the Medicare economic index (MEI) or the Consumer Price Index (CPI-U). Some services, such as dialysis services do not have a specific annual update.

Explanation of Provision.—For each year, beginning with 1996, the Secretary would determine for each class a uniform percentage increase that would apply to the payments rates for services within the class. The uniform percentage increase would be determined such that the estimated payments for services within the class for the year would be equal to the combined allocation to the class for the year.

Current law provisions providing for specific updates to services would be repealed. All services, consistent with establishment and updating of the Medicare health expenditure estimate, would be updated on January 1 of each year, beginning with 1996.

Effective Date.—Effective for updates to services implemented on or after July 1, 1995.

Sec. 15. Monitoring of Health Spending

Present Law.—The Secretary of HHS contracts with entities known as fiscal intermediaries and carriers to process Medicare claims.

The Medicare Cost Report (MCR) has been used since the inception of the Medicare program. Its main purpose is to determine the reimbursable cost of hospital-provided services and to determine Medicare's share of these costs. After implementation of the prospective payment system for hospitals, its main focus has shifted to determining Medicare cost-based payments for hospital outpatient services and the direct costs of graduate medical education. Over 90 percent of all acute care hospitals submit their cost reports electronically.

Explanation of Provision.—Under Medicare Part C, all claims for services would be submitted to Medicare's fiscal intermediaries and carriers.

The Secretary would monitor spending under Medicare (including Medicare Part C) to ensure that the updates for each of the various payment rates are consistent with the Medicare health expenditure estimate. The primary source of such information would be claims submitted to Medicare by providers.

All providers who submit claims to either Medicare or to private payers would be required to submit uniform annual reports to the Secretary of HHS to be used in monitoring and enforcing compliance with the national Medicare and private health spending estimates.

The Secretary would establish the requirements for such reports. The Secretary also would provide for a method by which these reports could be submitted electronically.

Hospitals and other facilities and institutions would provide cost and revenue data; other providers would submit only revenue data. The reports would include information on all revenues received during the preceding calendar year relating to medical services provided to all patients, broken down separately by class of service and type of payer (Medicare A, B and C, Medicaid, CHAMPUS, private insurance plans, and direct patient out-of-pocket costs).

Reports would be submitted by April 15 of each year, and would include data with respect to the preceding calendar year. The initial report, covering payments made for services provided in 1996, would be due on April 15, 1997. Information collected under this system would not be disclosed in a manner that would permit the identification of individual providers of services.

Revenues for activities not related to the provision of direct patient care, such as teaching or research, or for services that are explicitly excluded from the system of national health expenditures estimates, would be reported separately.

Hospitals' reports for inpatient and outpatient services would be part of the uniform hospital reporting system established in title IX.

Physicians and other providers would submit reports in a form to be specified by the Secretary.

The Secretary may, where appropriate, provide for the collection of data through surveys of a sample of health providers. Prior to April 15, 1997, the Secretary may use such other data collection and estimation techniques as may be appropriate.

Providers who fail to provide such information, or who deliberately provide false information would be subject to civil monetary

penalties not to exceed \$10,000 for each refusal or provision of false information.

Effective Date.—Effective upon the date of enactment.

Sec. 16. Allocation of Health Spending to States

Present Law.—(a) Allocations to States—No provision.

(b) Determination of State adjustment factors.—No provision.

(c) Adjustments for Medicare Part C and new benefits.—No provision.

(d) Recommendations by commissions.—No provision.

Explanation of Provision.—(a) Allocations to States.—The Secretary would establish a State Medicare per capita estimate for each State for each year to monitor the States' success in controlling costs. The State private per capita estimate would be equal to the national Medicare per capita estimate multiplied by an adjustment factor that reflects the relative cost and use of services by residents of the State who are covered under the Medicare programs (including Medicare Part C).

The Secretary would, in conjunction with the publication of the national private per capita estimate, publish the allocation of the national private per capita estimate to each State. The Secretary would report such allocations to Congress and to each State.

(b) Determination of State Adjustment Factors.—The Secretary would establish a State adjustment factor for each State in 1995. The adjustment factor would be equal to the ratio of the State Medicare per capita estimate to the national Medicare per capita estimate.

The Secretary would calculate, for each State, a State Medicare per capita health estimate for 1995 in the same manner as the national Medicare per capita estimate is calculated. Specifically, the Secretary would compute a baseline State Medicare Part A and Part B per capita estimate for 1993. The estimate would be based on actual expenditures under the Medicare program, excluding payments that are excluded from the system of estimates, divided by the number of persons eligible for benefits under Medicare in 1993. This amount would be update to 1995 using the baseline estimate of growth in Medicare expenditures per capita.

In determining the State adjustment factors, the Secretary would establish them in a manner such that the population weighted average of the adjustment factors is equal to one.

The Secretary would adjust the State Medicare per capita estimates to take into account differences among States in the in-State use of services by out-of-State residents, and the out-of-State use of services by State residents, such that the allocation in 1995 reflects services used by State residents anywhere in the United States.

As under the system of national health expenditure estimates, the Secretary would not be permitted to adjust the State Medicare per capita estimates or the adjustment factors once established. The only adjustment that would be permitted would be adjustments to correct errors in the estimation of the base year (1995) amounts. Specifically, the estimate for 1995 could be amended by the Secretary to correct errors in the estimation of initial spending relative to the predicted level. The Secretary would be permitted to

make conforming changes to the estimates for years after 1995 if the 1995 estimate is changed under this provision.

(c) Adjustments for Medicare Part C and new benefits.—Consistent with the adjustment to the national Medicare spending estimates, the State per capita estimates would be uniformly adjusted to reflect implementation of Medicare Part C and the new Medicare benefits and savings provisions as provided in titles III and VIII.

In addition, beginning in 1998, the estimates of the State Medicare per capita estimates would be equal to the weighted average of the State Medicare Part A and Part B and State Medicare Part C per capita estimates to reflect the variations in enrollment in Part C for each State.

(d) Recommendations by commissions.—ProPAC, PPRC, and DrugPRC would make periodic reports to the Congress on the allocation of the national health expenditure estimate to the States. These reports should include such recommendations as the Commissions deem appropriate.

Effective Date.—Effective upon the date of enactment.

Sec. 17. Administrative and Judicial Review

Present Law.—Medicare's prospective payment system for inpatient hospital services was enacted in the Social Security Amendments of 1983. In this Act, certain elements of this payment reform were exempt from both administrative and judicial review. When Medicare's physician payment reform was enacted in the Omnibus Reconciliation Act of 1989, a similar provision was included that prohibited administrative and judicial review of the Secretary's estimates of certain components of the reformed payment system.

Explanation of Provision.—There would be no administrative or judicial review of the Secretary's determination of: (i) the national Medicare per capita estimates and the State Medicare per capita estimates for each State; (ii) the allocation of such estimates to classes of health services; or (iii) the trend factors used in determining the allocations.

Effective Date.—Effective upon the date of enactment.

Subtitle D. Additional Medicare savings

Sec. 18. Indirect Medical Education

Present Law.—Under the prospective payment system for inpatient hospital services, Medicare pays teaching hospitals an additional amount to reflect the indirect costs associated with graduate medical education programs. Payment for each Medicare discharge is increased by approximately 7.65 percent, on a curvilinear basis, for each 10 percent increase in the ratio of interns and residents-to-beds.

Explanation of Provision.—The indirect medical education adjustment paid under the Medicare prospective payment system, for both Medicare Part A and Medicare Part C would be phased down from 7.65 percent to 5.2 percent beginning with the implementation of Medicare Part C.

The formula factor would be reduced from 7.65 percent to 6.8 percent for discharges occurring on or after January 1, 1998, through September 30, 1998.

The formula factor would be reduced from 6.8 percent to 6.0 percent for discharges occurring on or after October 1, 1998, through September 30, 1999.

The formula factor would be reduced from 6.0 percent to 5.2 percent for discharges occurring on or after October 1, 1999.

Effective Date.—Effective beginning with discharges occurring on or after January 1, 1998.

Sec. 19. Disproportionate Share Adjustment

Present Law.—Under the prospective payment system, Medicare provides additional payments to hospitals serving a disproportionate share of low-income patients. The adjustment amount is determined using formulas based on the disproportionate patient percentage. The disproportionate patient percentage is defined as the sum of the percentage of total patient days that are attributed to non-Medicare-eligible Medicaid beneficiaries and the percentage of Medicare patient days that are attributed to Medicare beneficiaries that are also eligible for Supplemental Security Income benefits. Separate formulas are provided for various categories of urban and rural hospitals.

Explanation of Provision.—The disproportionate share adjustment paid under the Medicare prospective payment system for both Medicare Part A and Medicare Part C would be phased down beginning with the implementation of Medicare Part C.

Effective for discharges occurring on or after January 1, 1998, and before October 1, 1999, the Secretary would be required to reduce payments that would otherwise be made under the disproportionate share adjustment by 25 percent. The reduction would be limited to 10 percent for urban hospitals with more than 100 beds and rural hospitals with more than 500 beds and a disproportionate patient percentage under the existing formula that is greater than 30 percent.

Effective for discharges occurring on or after October 1, 1999, the Secretary would be required to reduce payments that would otherwise be made under the disproportionate share adjustment by 50 percent. The reduction would be limited to 25 percent for urban hospitals with more than 100 beds and a disproportionate patient percentage under the existing formula that is greater than 30 percent.

The Secretary would be directed to propose a modification to the definition of “disproportionate patient percentage” in order to take into account the repeal of inpatient hospital coverage under Medicaid and the establishment of Medicare Part C. This report would be due no later than October 1, 1995. The Prospective Payment Assessment Commission would be directed to review the Secretary’s proposal and to make a recommendation regarding the appropriate modification to the definition in its March 1, 1996 annual report.

Effective Date.—Reductions would be effective beginning with discharges occurring on or after January 1, 1998. Other provisions would be effective upon the date of enactment.

Sec. 20. Inpatient Hospital Capital

Present Law.—Medicare pays hospitals for inpatient capital expenses under a prospective payment system. During a ten-year transition that began in fiscal year 1992, hospitals are paid based on a blend of Federal rates and hospital-specific capital rates. The initial Federal rate was computed based on unaudited 1989 cost-report data, trended forward to 1992. The hospital-specific rates were based on data from the hospital's 1990 cost report, trended forward to 1992. The Federal and hospital-specific rates are updated annually for inflation.

The Omnibus Budget Reconciliation Act of 1993 reduced the Federal capital rate by 7.4 percent to correct errors in the inflation forecasts used to establish the Federal rates.

Explanation of Provision.—Adjustments would be made to the Federal and hospital-specific capital payment rates. The adjustments are intended to remove the effects of errors in inflation forecasts in addition to those corrected in OBRA 93. The Federal capital payment rate would be reduced by 7.31 percent. The hospital-specific capital payment rates would be reduced by 10.41 percent.

Effective Date.—Effective for discharges occurring on or after October 1, 1995.

Sec. 21. Payments for Physician Services Relating to Inpatient Stays in Certain Hospitals

Present Law.—Under current law, there generally are no adjustments to amounts payable to physicians when covered services are provided to inpatients of hospitals. Each physician submits claims for his or her own services, and the amounts paid are determined under the RB RVS. The only exceptions to this general rule are when physicians provide services as a surgical team or when they supervise services provided by certified registered nurse anesthetists.

Explanation of Provision.—The Secretary would develop for all PPS hospitals, an annual, hospital-specific per-admission relative value scale and determine whether a hospital's specific per admission relative value exceeds the allowable average per admission relative value applicable to the medical staff for the year. If the Secretary determines that the rate for the hospital exceeds the allowable average per admission, the Secretary would reduce payments for the physician services to hospital inpatients. By October 1 of each year, the Secretary would notify each hospital of its specific relative values.

In the case of urban hospitals, the allowable average per admission relative value would be equal to 125 percent, for admissions in 1998 and 1999, and 120 percent thereafter of the median 1996 hospital-specific relative value per admission for all hospital medical staffs.

In the case of rural hospitals for each year beginning with 1998, the allowable per admission relative value would be equal to 140 percent of the median 1996 hospital-specific relative value per admission for all hospital medical staffs.

The hospital specific projected relative values for a hospital would be equal to the average relative values per admission for

physician services furnished to inpatients during 1996 by the hospital's medical staff and billed to Medicare, adjusted for variations in case mix, the disproportionate share adjustment, and indirect teaching adjustment, if applicable.

The projected excess relative value for a year would mean the number of percentage points (as determined by the Secretary) by which a medical staff's hospital specific per admission relative value exceeds the allowable average per admission relative value.

The amount of payments otherwise due would be reduced by 15 percent for each service furnished for hospitals whose relative value per admission exceeds the allowable average per admission.

Not later than October 1 each year, beginning in 1999, the Secretary would determine each hospital's actual average per admission relative value using claims forms submitted not later than 90 days after the last day of the previous year, adjusted for case mix, and the disproportionate share and indirect teaching adjustments.

In cases in which a hospital's actual average per admission relative value was reduced and was below the allowable average rate, the Secretary would reimburse the hospital medical staff's fiduciary agent the amount that was withheld plus accrued interest. In cases where the actual average relative value is less than 15 percentage points above the allowable average, the Secretary would reimburse the hospital medical staff's fiduciary agent an amount equal to the difference between 15 percentage points and the actual number of percentage points by which the staff exceeded the allowable average per admission relative value plus accrued interest.

Hospital medical executive committees would be given a one-year advance notice of projected excessive relative values and would designate a fiduciary agent to receive and disburse amounts withheld by the Secretary that are subsequently returned. Alternatively, the Secretary could distribute such amounts directly to physicians who treated patients in the hospital on a pro-rata basis based on the proportion of services provided by each physician during the year.

Effective Date.—Effective for services provided on or after January 1, 1998.

Sec. 22. Medicare Secondary Payer

Present Law.—(a) Extension of transfer of data.—OBRA 89 authorized the establishment of a database to identify working beneficiaries and their spouses to improve identification of cases in which Medicare is secondary to third-party payers. The data match links Internal Revenue Service (IRS) tax records with data from the Social Security Administration (SSA) and the Health Care Financing Administration (HCFA). OBRA 90 extended the requirements pertaining to identification of secondary payer situations through September 30, 1995. OBRA 93 authorized an extension of the transfer of data through September 30, 1998.

(b) Extension of Medicare secondary payer for disabled beneficiaries.—Medicare is secondary payer to certain group health plans offered by employers of 100 or more employees for disabled beneficiaries. The authority for this provision expires September 30, 1998.

(c) Extension of 18-month rule for ESRD beneficiaries.—Medicare is secondary payer to certain employer group health plans covering

beneficiaries with end stage renal disease (ESRD) during the first 18 months of a beneficiary's entitlement to Medicare on the basis of ESRD. The authority for this provision expires September 30, 1998.

(d) Late payment penalty.—Primary payers are required to make payments for any item or service for which Medicare is secondary payer when they receive notice that payments are due. The Secretary is authorized to charge interest on late recoveries under the Medicare Secondary Payer program.

Explanation of Provision.—(a) Extension of transfer of data.—The authority for the transfer of data would be extended.

(b) Extension of Medicare secondary payer for disabled beneficiaries.—The Medicare secondary payer requirements for disabled beneficiaries would be extended.

(c) Extension of 18-month rule for ESRD beneficiaries.—The Medicare secondary payer requirements for beneficiaries with ESRD would be extended.

The provision would clarify that, in the case of individuals who become entitled to Medicare due to ESRD, regardless of whether the beneficiary is also entitled to Medicare on the basis of age or disability, the 18-month coordination period during which an employer plan must be primary would not be applied to persons for whom Medicare was already primary, such as a retiree (or spouse) over age 65 eligible for Medicare on the basis of age, who then is diagnosed with ESRD.

(d) Late payment penalty.—A late penalty would be imposed on primary payers who delay reimbursing the Medicare program for payments erroneously paid by Medicare. The amount of the penalty would equal one percent per month (or partial month) of the amount owed, commencing 60 days after the demand for payment. The penalty would be in addition to interest charged by the Secretary.

Effective Date.—Effective upon the date of enactment.

Sec. 23. Home Health Coinsurance

Present Law.—Medicare coverage of home health services is not subject to coinsurance. There is no explicit limit on the number of home health visits covered under Medicare. Although home health services are covered under Medicare Part B, an individual who is covered under both programs will receive benefits under Medicare Part A.

Explanation of Provision.—A twenty percent coinsurance would be imposed on home health services covered under Medicare Parts A and B.

Effective Date.—The coinsurance would be imposed on services provided on or after January 1, 1998.

Sec. 24. Home Health Cost Limits

Present Law.—Home health services are reimbursed on a reasonable cost basis, subject to aggregate cost limits. The limits are established at 112 percent of the mean labor-related and non labor per visit costs for freestanding home health agencies, and are updated annually. OBRA 93 provided that home health cost limits

would not be updated for cost reporting periods beginning during fiscal years 1994 and 1995.

Explanation of Provision.—Home health limits would be established at 100 percent of the mean per visit cost, adjusted by such an amount as the Secretary determines to be necessary to preserve the savings resulting from the enactment of the two-year freeze enacted in OBRA 93.

Effective Date.—Effective for cost reporting periods beginning on or after July 1, 1996.

Subtitle E. Minor and Technical Amendments

Sec. 25. Medicare Part A

Present Law.—(a) Hospital Wage Index—Hospitals may apply to the Medicare Geographic Reclassification Review Board for a change in geographic classification for the purposes of determining the hospital's area wage index under the prospective payment system. The Secretary publishes guidelines for use by the Board in rendering decisions on applications for a change in geographic classification, including guidelines for comparing wages, taking into account occupational mix. The labor market areas used to compute the area wage index adjustment are based on Metropolitan Statistical Areas (MSAs). Each of the standardized amounts (large urban, other urban, and rural) are separated into labor-related and non labor-related portions, with only the labor-related portion adjusted for differences in area wages.

(b) Rural health transition grants.—OBRA 87 instituted a program of grants to assist rural hospitals with fewer than 100 beds in developing and implementing projects to modify the type and extent of services they provide. Grants may be used to develop health systems with other providers, diversify services, recruit physicians, and improve management systems. The program is authorized at \$25 million per year for fiscal years 1990 through 1992.

(c) State hospital payment program.—Under Section 1814(b) of the Social Security Act, the Secretary may provide that Medicare payments to hospitals in a State be made in accordance with a State hospital reimbursement system meeting certain standards. The State system must meet requirements pertaining to the rate of increase in hospital costs per admission for Medicare beneficiaries occurring under the State system relative to the national average.

(d) Psychology services in hospitals.—Clinical psychologists are authorized to provide qualified psychologist services to Medicare beneficiaries. In order to participate in Medicare, hospitals must require that all Medicare patients are under the care of a physician, defined to include doctors of medicine, osteopathy, dentists, podiatrists, chiropractors, and optometrists practicing within the scope of State law. Certain States authorize psychologists to supervise the care of inpatients receiving psychologist services.

(e) Skilled nursing facility wage index.—Skilled nursing facilities are reimbursed on a reasonable cost basis, subject to per-diem limits. The limits are adjusted to reflect differences in area wages. In applying the wage index adjustment, the Secretary currently uses a wage index based on wage data collected from hospitals. In its

March 1, 1992 Report and Recommendations to the Congress, the Prospective Payment Assessment Commission recommended that the Secretary collect data on employee compensation and paid hours of employment for nursing facilities for the purpose of implementing a nursing facility wage index to adjust Medicare skilled nursing facility payments.

(f) Skilled nursing facility reimbursement for atypical services.—Medicare provides exceptions to the reimbursement limits that apply to skilled nursing facilities, so long as the facility demonstrates to the satisfaction of the Secretary that it furnishes atypical services to Medicare beneficiaries.

(g) Coverage of independent laboratory services in skilled nursing facilities.—Medicare provides for Part A coverage of laboratory tests for skilled nursing facility patients only if the skilled nursing facility has its own qualified laboratory or obtains the services from a hospital with which it has a transfer agreement.

(h) Hospice notification.—Hospitals are required to meet Medicare conditions of participation in order to receive reimbursement for treatment of Medicare beneficiaries. Conditions of participation for discharge planning in hospitals require an evaluation of a patient's likely need for appropriate post-hospital services and the availability of those services.

(i) Prospective payment assessment commission.—Members of the Prospective Payment Assessment Commission are appointed by the Director of the Office of Technology Assessment. Membership is specified to include individuals with national recognition for their expertise in health economics, hospital reimbursement, hospital financial management, and other related fields.

(j) Transfer cases.—The Secretary defines transfer cases and determines payment amounts for transfer cases under the prospective payment system for hospitals.

(k) Hemophilia pass-through extension.—Additional payments are made for the costs of administering blood clotting factor to Medicare beneficiaries with hemophilia admitted for hospital stays. OBRA 93 extended these payments for clotting factor furnished through September 30, 1994.

(l) Sub-acute demonstration project.—No provision.

(m) Nursing home reform amendments.—(i) Suspension of De certification of Nurse Aide Training and Competency Evaluation Programs Based on Extended Surveys.—Nurse aide training and/or competency evaluation programs may not be offered by or in a skilled nursing facility (SNF), which, within the previous two years, has been subject to an extended (or partially extended) survey. These surveys are conducted as a result of a finding that a facility has been providing substandard care to Medicare or Medicaid beneficiaries. The SNF may not operate a training or competency evaluation program, even if it has corrected the deficiencies that led to the extended survey.

(ii) Requirements for consultants conducting reviews on use of drugs.—An independent, external consultant is required to review, on an annual basis, the appropriateness of the written drug plan established for each SNF resident receiving psychopharmacologic drugs. The Health Care Financing Administration published proposed regulations in February 1992 that would require the inde-

pendent, external consultant to be a physician who has training or experience in geriatrics and psychopharmacology, and who has not had a contractual, financial, employment or familial relationship with the facility during any of the 36 months prior to the review.

(iii) Increase in minimum amount required for separate deposit of personal funds.—SNFs must deposit any amount of a resident's personal funds in excess of 50 dollars in an interest bearing account that is separate from any of the facility's operating accounts, and must credit all interest to the separate account.

(iv) Due process protections for nurses aides.—States are required to establish and maintain a nurse aide registry of all persons who have satisfactorily completed a training and/or competency evaluation program. The registry must include specific documented findings of neglect or abuse or misappropriation of resident property by an aide listed in the registry, as well as any brief statement of the aide disputing the findings. States are also required to provide for a process for the timely review and investigation of allegations of neglect, abuse, and misappropriation of resident property by an aide. After notice to the aide involved, the State must provide a reasonable opportunity for a hearing for the aide to rebut the allegations, and then made a finding as to the accuracy of the allegations.

(v) Technical corrections.—OBRA 90 included a number of amendments to the nursing home reform amendments originally enacted in 1987.

(n) Other technical amendments to Part A.—Under the "DRG window" provision, services provided by a hospital (or an entity wholly owned or operated by the hospital) to an inpatient of a hospital during the three days prior to admission are not separately reimbursed under part B of Medicare if they are diagnostic services or otherwise related to the admission. OBRA 93 modified payments to Medicare dependent and sole community hospitals. The part A provisions of OBRA 90 and OBRA 93 included clerical errors.

Explanation of Provision.—(a) Hospital wage index.—The Secretary would be authorized to account for occupational mix in reclassification criteria where appropriate. The statute would be clarified to indicate that if labor market areas are no longer based on Metropolitan Statistical Areas (MSAs), the current method of calculating the area wage index based on MSAs would no longer apply and the guidelines for the Medicare Geographic Classification Review Board may be modified. The Secretary would be directed to establish the labor and non-labor portions of each of the standardized amounts based on the national average proportions, effective October 1, 1994.

(b) Rural health transition grants.—Appropriations for the rural health transition grant program would be authorized at \$30 million a year for fiscal years 1993 through 1997. Rural primary care hospitals would be eligible for grants.

The purposes of the transition grant program would be modified to authorize grants for demonstration projects to establish telecommunications linkages between rural facilities and other medical facilities that have expertise or equipment that can be used by the rural facilities through telecommunications. The technologies demonstrated under the grant program would include interactive video

telecommunications, static video imaging transmitted through the telephone system, and facsimiles transmitted through the telephone system. Two million dollars of funds appropriated for the rural health transition grant program would be set aside for such telecommunications projects.

(c) State hospital payment program.—No other provision of law would prohibit a State with a hospital payment waiver under section 1814(b) of the Social Security Act from requiring that payment for covered services be made under the State system.

(d) Psychology services in hospitals.—In a State in which such supervision is authorized by State law, the care of hospital inpatients receiving qualified psychologist services could be supervised by a clinical psychologist with respect to such services to the extent permitted by State law.

(e) Skilled nursing facility wage index.—The Secretary would be required to begin collecting the data necessary to compute a wage index based on wages specific to skilled nursing facilities (rather than hospitals) within one year of enactment. The Prospective Payment Assessment Commission would be required to study and report by March 1, 1995 on the impact of applying routine per-diem cost limits on a regional basis.

(f) Skilled nursing facility reimbursement for atypical services.—The Secretary would be required to establish an expedited review process for atypical services exceptions, including exceptions based on facility case mix, by no later than October 1, 1994. The process would provide for intermediary review within 30 days of submission. If an exception is granted for atypical services provided on a continuing basis, the Secretary would provide for timely readjustments to facility interim payments to recognize the additional costs associated with atypical services.

(g) Coverage of independent laboratory services in skilled nursing facilities.—Medicare Part A coverage of laboratory tests for skilled nursing facility patients would include payment for laboratory services provided by an independent laboratory.

(h) Hospice notification.—Hospital conditions of participation with respect to discharge planning would be modified to require an evaluation of a patient's likely need for appropriate post-hospital services, including hospice services, and the availability of those services.

(i) Prospective payment assessment commission.—Expertise of individuals to serve on ProPAC would be clarified to include individuals with expertise in facilities management, reimbursement of health facilities or other providers of services which reflect the scope of the Commission's responsibilities.

(j) Transfer cases.—The Secretary would be authorized to make budget neutral changes in the payment policy for transfer cases under the prospective payment system.

(k) Hemophilia pass-through extension.—The pass-through payments would be extended through September 30, 1999.

(l) Sub-acute demonstration project.—The Secretary of Health and Human Services would be required to conduct a demonstration project of sub-acute care services in free-standing facilities and hospitals under the Medicare program. The Secretary would be required to submit a report on findings from the demonstration to

the Congress, including legislative recommendations, by no later than three years after the date of enactment.

(m) Nursing home reform amendments.—

(i) Suspension of decertification of nurse aide training and competency evaluation programs based on extended surveys.—SNFs would be permitted to offer nurse aide training and/or competency evaluation programs if the extended or partial extended survey showed that the facility is in compliance with certification requirements pertaining to the provision of services, residents' rights, and administration and other matters.

(ii) Requirements for consultants conducting reviews on use of drugs.—In determining whether a consultant is qualified to conduct reviews, the Secretary would be required to take into account the needs of facilities to have access to the services of a consultant on a timely basis.

(iii) Increase in minimum amount required for separate deposit of personal funds.—The minimum amount for a separate account for personal funds of residents of SNFs would be increased to \$100.

(iv) Due process protections for nurses aides.—States would be prohibited from including in their nurse aide registries any allegations of resident abuse, neglect, or misappropriation of resident property that are not specifically documented by the State in its investigation and hearing process. The amendment also provides that the State would be required to provide an aide with a written notice of allegation (including a statement of the availability of a hearing for the aide to rebut the allegation) and the opportunity for a hearing on the record, and then the State would make a written finding as to the accuracy of the allegations.

(v) Technical corrections.—A number of technical corrections would be made to nursing home reform amendments included in OBRA 90.

(n) Other technical amendments to Part A.—The DRG window provision would be clarified with respect to hospitals that are not paid on the basis of DRGs. For these hospitals, services provided during the one day prior to admission would not be separately reimbursed under part B of Medicare if they are diagnostic services or otherwise related to the admission. Changes in payments to Medicare dependent and sole community hospitals made in OBRA 93 would be clarified. Other minor technical corrections would be made.

Effective Date.—Provisions (a) through (g), (i) through (l) and (n) would be effective upon the date of enactment. Provision (h) would apply to services furnished on or after the first day of the first month beginning more than one year after the date of enactment. Provisions (m)(i) and (m)(v) would be effective as if they were included in OBRA 90. Provisions (m)(ii) would be effective as if included in OBRA 87. Provisions (m)(iii) and (m)(iv) would be effective January 1, 1995.

Sec. 26. Medicare Part B—Physician Services

Present Law.—(a) Development and Implementation of resource-based methodology for practice expenses.—Under the Resource-based Relative Value Scale (RB RVS) for physician services, the relative values are equal to the sum of three components: the work

component related to the physician's time and effort, a practice expense component, and a malpractice component. Under current law, the work component is based on the estimated physician resources consumed in providing the service. The practice expense component is based on relative charges for services in 1991. OBRA 89 required the Physician Payment Review Commission to conduct a study of using relative resources as the basis for determining the relative values of the practice expense component.

(b) Geographic practice cost index (GPCI) refinement.—Physician payments under the RB RVS are adjusted by a geographic index that is intended to measure local variations in the cost of practicing medicine. Separate adjustments have been developed for each of the three components of the RB RVS. The current index is based, in part, on data from the 1980 census. The Secretary is required to review and update the geographic adjustment index not less often than every three years.

(c) Extra-billing limits.—

(i) Limitations on beneficiary liability.—OBRA 89 established limits on the amount above the Medicare approved payment amount non participating physicians may charge Medicare beneficiaries. OBRA 89 permitted the Secretary to impose sanctions on physicians who knowingly and willfully bill above the limiting charge on a repeated basis. However, it did not specifically prohibit physicians from billing beneficiaries more than the limiting charge. OBRA 89 also did not require physicians to make refunds to beneficiaries when they billed above the limiting charge and did not absolve beneficiaries from liability for amounts billed above the Medicare limiting charge.

(ii) Pre-payment screening of claims.—Carriers are not currently required by law to screen unassigned claims submitted by non participating physicians prior to payment in order to determine whether the amount billed exceeds the limiting charge.

(iii) Information regarding limiting charges.—There is currently no statutory requirement that beneficiaries be given information on the Explanation of Medicare Benefits (EOMB) form if physicians have charged beneficiaries in excess of the limiting charge.

(iv) Clarification of mandatory assignment rules for certain practitioners.—There is some ambiguity in current law regarding the application of mandatory assignment rules for certain nonphysical practitioners.

(d) Relative values for pediatric services.—No provision.

During the development of the RB RVS by Harvard University, pediatric services were included in the initial study. These data were not fully refined by Harvard nor were they refined by the Secretary during further development of the RB RVS.

(e) Administration of claims relating to physician services.—OBRA 90 permitted physicians to submit a claim for a service provided by a second physician when the first physician was not available to provide the service. Such billing was permitted only in cases where the arrangement is temporary and reciprocal.

(f) Miscellaneous and technical corrections.—

(i) Overvalued procedures.—OBRA 90 subjected all unsurveyed overvalued services to a 6.5 percent reduction unless the law specifically exempted them from the reduction. Unsurveyed services

are those not included in earlier surveys conducted to determine relative values of physicians' services; these unsurveyed services were considered to be overvalued. The list of services specifically exempted from the 6.5 percent reduction contained certain errors.

(ii) Radiology services.—OBRA 90 reduced the locally defined conversion factors for radiology services paid on the basis of the radiology fee schedule. The maximum reduction was not to exceed 9.5 percent. However, OBRA 90 contained an error that would increase conversion factors in some localities.

(iii) Anesthesia services.—OBRA 87 established a fee schedule for anesthesia services based on a relative value guide for anesthesia services and local conversion factors. OBRA 90 reduced the local conversion factors. The maximum reduction was not to exceed 9.5 percent. However OBRA 90 contained an error that would increase the conversion factors in some localities.

(iv) Assistants at surgery.—OBRA 90 specified that payment to a physician serving as an assistant at surgery cannot exceed 16 percent of the payment made for the global surgical service.

(v) Technical components of diagnostic services.—OBRA 90 capped the reasonable charge for technical components of specified diagnostic services at the national median charge for the service in all localities.

(vi) Statewide fee schedules.—OBRA 90 required the Secretary to treat the States of Nebraska and Oklahoma as statewide payment localities if they met certain requirements specified in the law. Each member of the Congressional delegation from those States and organizations representing urban and rural physicians would have to agree to the statewide locality provision. This requirement raised constitutional concerns relating to the separation of powers between the executive and legislative branches.

(vii) Reciprocal billing arrangements.—OBRA 90 permitted physicians to submit a claim for a service provided by a second physician when the first physician was not available to provide the service. Such billing was permitted only in cases where the arrangement is temporary and reciprocal.

(viii) Study of aggregation rule for claims of similar physician services.—OBRA 90 required the Secretary to study the effects of aggregating physician claims and report to the Congress by December 31, 1992.

(ix) Other miscellaneous and technical amendments.—A number of technical and drafting errors were contained in OBRA 90.

Explanation of Provision.—(a) Development and implementation of resource-based methodology for practice expenses.—The Secretary would establish resource-based relative values for the practice expense component of the RB RVS. The use of these units as the basis of payments would be implemented on a budget neutral basis as of January 1, 1997. The methodology used in developing these estimates would recognize the staff, equipment and supplies used in the provision of various medical and surgical services in various settings. The Secretary would provide a report to the Ways and Means Committee on the methodology by July 1, 1995, including a presentation of the data used in developing the methodology.

(b) Geographic practice cost index (GPCI) refinement.—The Secretary would be required to use the most recent data available in

determining the geographic adjustments relating to variations in the cost of living, cost of practice and cost of malpractice among physician payment localities.

Within one year of enactment, the Secretary would study and report to Congress on the data necessary to revise and review the geographic indices, on limitations of existing data, and on ways and costs of addressing such limitations.

(c) Extra-billing limits.—

(i) Limitations on beneficiary liability.—Non participating physicians and non participating suppliers would be prohibited from billing or collecting from any person an actual charge in excess of the Medicare limiting charge. No person would be liable for payment of any amount billed in excess of the limiting charge. Physicians, suppliers and other persons who bill or collect amounts exceeding the limiting charge would be required to: (1) refund the full amount collected in excess of the limiting charge; (2) reduce the outstanding balance owed for other items and services furnished to the individual by the amount of the charge exceeding the limiting charge and refund any amount in excess of the outstanding balance; or (3) in the case of excess charges that not been collected by the physician, reduce the actual charge billed for the service to the amount approved by Medicare.

Carriers would be required to notify a physician, supplier or other person within 30 days if they have billed in excess of the limiting charge. The physician, supplier or other person would be required to refund or credit excess charges within 30 days after the date the physician, supplier, or other person is notified by the carrier of the violation.

A physician, supplier or other person who (1) knowingly and willfully bills or collects amounts in excess of the limiting charge on a repeated basis; or (2) fails to comply with the refund requirements would be subject to sanctions in accordance with Section 1842(j) of the Social Security Act.

Medicare carriers currently ask for a refund where the actual charge exceeds the limiting charge by at least one dollar. Similarly, Medicare carriers include information on the Explanation of Medicare Benefits form where the limiting charge exceeds the actual charge by at least one dollar. The use of a one dollar nominal threshold before application of the refund provision (as well as for the reduction of an actual charge where the physician has not collected and for the EOMB) is an appropriate policy that would be consistent with this provision.

(ii) Pre-payment screening of claims.—Carriers would be required to screen 100 percent of unassigned claims submitted by non-participating physicians prior to making payment to determine whether the amount billed exceeds the limiting charge.

(iii) Information regarding limiting charges.—Carriers would be required to provide limiting charge information on the Explanation of Medicare Benefits form after the submission of an unassigned claim which exceeds the limiting charge, and to include on such forms information relating to the beneficiary's right to a refund of any excess amounts collected.

The Secretary would report to the Congress annually on the extent to which annual charges exceeded limiting charges, the num-

ber and types of services involved, and the average amount of excess charges.

(iv) Clarification of mandatory assignment rules for certain practitioners.—Specifies that physicians' assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers and clinical psychologists could only bill for services on an assignment-related basis and that no person is liable for amounts billed in violation of the assignment-related basis. The Secretary could impose sanctions under Section 1842(j) of the Social Security Act on a practitioner who knowingly and willfully bills in violation of this requirement.

(d) Relative values for pediatric services.—The Secretary would fully develop and refine by January 1, 1995 the relative values for the full range of pediatric services. The Secretary would conduct a study of the relative values for pediatric and other services to determine whether there are significant variations in the resources used in providing similar services to different populations. In conducting the study, the Secretary would consult with appropriate organizations representing pediatricians and other physicians, and submit a report to the Congress by July 1, 1995.

(e) Administration of claims relating to physician services.—The Secretary would be prohibited from imposing any fees related to the filing of claims for physicians' services, for claims errors or denials, for administrative appeals, for obtaining unique identifier numbers, or for responding to inquiries concerning the status of pending claims.

The Secretary would be permitted to recognize substitute billing arrangements between two physicians. In order to be recognized, such substitute billing arrangements would be required either to be informal, reciprocal, coverage agreements or per diem or other fee-for-time agreements. The duration of such agreements would be limited to 60 continuous days, and claims for services provided pursuant to such agreements would be required to include the unique identifying number of both physicians. These requirements would be effective for services provided under such arrangements in the first month beginning more than 60 days after the enactment of this Act.

(f) Miscellaneous and technical corrections.—

(i) Overvalued procedures.—Some procedures would be deleted from the list of exempted services and errors in the names of other services would be corrected. The procedures that would be deleted from the list of exempted services are: lobectomy; enterectomy; colectomy; cholecystectomy; and sacral laminectomy.

(ii) Radiology services.—The conversion factors below the maximum reduction amount would not be permitted to be increased. The provision makes other technical changes to OBRA 90.

(iii) Anesthesia services.—The conversion factors below the maximum reduction amount would not be permitted to increase. The provision makes other technical changes to OBRA 90.

(iv) Assistants at surgery.—The application of the extra-billing limits to physicians serving as assistants at surgery would be clarified.

(v) Technical components of diagnostic services.—The limits on payment for the technical component of diagnostic services would not apply to services whose payments were reduced under the OBRA 89 overvalued procedure list.

(vi) Statewide fee schedules.—The OBRA 90 requirement for agreement from members of Congress would be eliminated, and Nebraska and Oklahoma would be statewide localities beginning in 1991.

(vii) Reciprocal billing arrangements.—OBRA 90 would be amended to clarify the services that may be covered under reciprocal billing. All physician services, including services incident to physician services, would be covered. The provision would also permit reciprocal billing arrangements that are both informal or reciprocal (as in current law) or involve per diem or other fee-for-time compensation.

(viii) Study of aggregation rule for claims of similar physician services.—The date that the study must be submitted to the Congress would be changed from December 31, 1992 to December 31, 1994.

(ix) Miscellaneous and technical amendments.—A number of technical and drafting errors contained in OBRA 90 would be made through minor and conforming amendments.

Effective Dates.—(a) Development and Implementation of Resource-based Methodology for Practice Expenses—Effective upon the date of enactment.

(b) Geographic practice cost index (GPCI) refinement.—Effective upon the date of enactment.

(c) Extra-billing limits.—Except as otherwise provided, subsection (i) would be effective upon the date of enactment, except as it applies to services of non-participating suppliers or other persons which would be effective for services furnished after January 1, 1995; subsection (ii) would be effective for contracts with carriers as January 1, 1995; subsection (iii) would be effective for forms provided on January 1, 1994; and subsection (iv) would be effective for services furnished on or after January 1, 1995.

(d) Relative values for pediatric services.—Effective upon the date of enactment.

(e) Administration of claims relating to physician services.—Effective upon the date of enactment.

(f) Miscellaneous and technical corrections.—Effective upon the date of enactment.

Sec. 27. Medicare Part B—Durable Medical Equipment

Present Law.—(a) Certification of suppliers.—There are no statutory standards that suppliers of durable medical equipment (DME), prosthetic devices, prosthetics and orthotics, surgical dressings, splints, casts, and other devices for fractures and dislocations, home dialysis supplies, and immunosuppressive drugs must meet in order to supply items to Medicare beneficiaries.

(b) Prohibition against multiple billing numbers.—No provision.

(c) Distribution of certificates of medical necessity.—OBRA 90 prohibited suppliers of durable medical equipment from distributing, for commercial purposes, completed or partially completed, cer-

tificates of medical necessity to physicians or Medicare beneficiaries.

(d) Studies.—

(i) Use of covered items by disabled beneficiaries.—No provision.

(ii) Variations in quality of equipment.—No provision.

(e) Restrictions on certain marketing and sales activity.—No provision.

(f) Anti-kickback clarification.—Current law exempts employees in bona-fide employment relationships from penalties assessed for knowingly and willfully soliciting or receiving remuneration (including kickbacks, bribes, or rebates) or offering or paying remuneration as an incentive for Medicare business.

(g) Limitations on beneficiary liability for non-covered services.—No provision.

(h) Adjustments for inherent reasonableness.—The Secretary is permitted to increase or decrease the Medicare DME fee schedules in cases where the payment amount is grossly excessive or grossly deficient and not inherently reasonable. Such adjustment must reflect costs in the base year of the fee schedules.

(i) Miscellaneous and technical corrections.—

(i) Updates to payment amounts.—OBRA 90 contains a drafting error regarding the update to the durable medical equipment fee schedule for 1991 and 1992.

(ii) Potentially overused items and advance determinations of coverage.—OBRA 90 included two provisions regarding special carrier review of potentially overutilized items and advance determinations of coverage for certain items. These two provisions were combined in drafting so that they do not properly reflect the conference agreement.

(iii) Study in variations in durable medical equipment supplier costs.—OBRA 90 provided for a system of upper and lower limits on DME fees. The OBRA 90 conferees agreed to a study of regional variations in durable medical equipment supplier costs which was not included in the statutory language.

(iv) Oxygen retesting.—OBRA 90 included a provision requiring periodic retesting of beneficiaries receiving oxygen if their initial blood gas reading value was at or above a partial value of 55.

(v) Other miscellaneous and technical amendments.—OBRA 90 contains drafting errors.

Explanation of provision.—(a) Certification of suppliers.—Suppliers of medical equipment and supplies (durable medical equipment, prosthetic devices, orthotics and prosthetics, surgical dressings and such other items as the Secretary may determine and home dialysis supplies and equipment and immunosuppressive drugs) would not be reimbursed for these items unless they have a Medicare supplier number. A supplier may not obtain a supplier number unless the supplier meets uniform national standards prescribed by the Secretary. By January 1, 1996, the Secretary would revise the standards.

The revised standards would require suppliers to: (i) comply with all applicable State and Federal licensure and regulatory requirements; (ii) maintain a physical facility and inventory on an appropriate site; (iii) have proof of appropriate liability insurance; and (iv) meet other requirements established by the Secretary. In addi-

tion, the requirement for suppliers to obtain a supplier number does not apply to medical equipment and supplies furnished as incident to a physician's service. The Secretary would be prohibited from delegating the responsibility to determine whether the supplier meets the standards necessary to obtain a supplier number.

(b) Prohibition against multiple billing numbers.—The Secretary would be prohibited from issuing more than one billing number to any supplier, unless the issuance of more than one number is appropriate to identify subsidiary or regional entities under the supplier's ownership or control.

(c) Distribution of certificates of medical necessity.—The OBRA 90 provision prohibiting suppliers of medical equipment and supplies from distributing completed or partially completed certificates of medical necessity would be modified. Suppliers of medical equipment and supplies would be able to distribute to physicians or individuals entitled to benefits under Medicare, a certificate of medical necessity, which contains no more than the following information completed by the supplier: (i) an identification of the beneficiary and supplier; (ii) a description of the item; (iii) any product code identifying the item; and (iv) any other information required by the Secretary. If a supplier provides any of the above information on a certificate of medical necessity, the supplier would be required to include the fee schedule amount and the supplier's charge prior to distribution to the physician for completion. Suppliers who violate the provisions would be subject to a civil money penalty in an amount not to exceed \$1,000 for each certificate of medical necessity so distributed.

(d) Studies.—

(i) Use of covered items by disabled beneficiaries.—The Secretary would study and report to the Congress on the effects of the methodology for determining payments for durable medical equipment items and supplies on the ability of persons entitled to disability benefits to obtain equipment, including customized items.

(ii) Variations in quality of equipment.—The Secretary would study and report to the Congress, describing prosthetic devices or orthotics and prosthetics that do not require individualized or custom fitting and adjustment and report an appropriate method for determining the amount of payment for such items under the program that do not require individualized or custom fitting and adjustment.

(e) Restrictions on certain marketing and sales activity.—Suppliers would be prohibited from making unsolicited telephone contacts with Medicare beneficiaries unless: (i) the individual has given written permission to the supplier; (ii) the supplier has furnished a covered item to the individual and the supplier is contacting the individual only regarding the furnishing of such covered item; or (iii) the supplier has furnished the individual with a covered item within the preceding 15 months. Medicare would not pay for items provided subsequent to a prohibited telephone contact. The Secretary would be required to exclude from programs under the Social Security Act suppliers who knowingly make prohibited telephone contacts to such an extent that the supplier's conduct establishes a pattern of contacts in violation of the prohibition. Beneficiaries would not be liable for the cost of items provided as a re-

sult of prohibited telephone contacts, and the supplier would be required to refund any amounts collected on a timely basis or be subject to certain sanctions.

(f) Anti-kickback clarification.—The exemption from anti-kickback penalties for employees in bona-fide employment relationships with providers of Medicare-covered services and supplies would not include the tasks of transmitting assignment rights of Medicare beneficiaries to suppliers of covered items, or performing warehousing or stock inventory functions.

(g) Limitations on beneficiary liability for non-covered services.—Medicare beneficiaries would not be financially liable for covered items furnished by a supplier on an unassigned basis if: (i) the supplier has failed to obtain a supplier number; (ii) Medicare has denied payment for the item in advance; or (iii) the item is denied as being medically unnecessary.

Medicare beneficiaries would not be financially liable for covered items furnished by a supplier on an assignment-related basis if: (i) the supplier has failed to obtain a supplier number; (ii) Medicare had denied payment for the item in advance; or (iii) the supplier made an unsolicited telephone contact in violation of the statute.

(h) Adjustments for inherent reasonableness.—The Secretary would determine whether the payment amounts for acute care mattresses, transcutaneous electrical nerve stimulators (TENS), and any other items considered appropriate by the Secretary are inherently reasonable and would adjust payments for these items if the amounts are not inherently reasonable. Adjustments for these items would be based on the prices and costs applicable at the time the item is furnished.

(i) Miscellaneous and technical corrections.—

(i) Updates to payment amounts.—The OBRA 90 error would be corrected by specifying that the 1991 and 1992 update is the CPI-U minus one percentage point.

(ii) Potentially overused items and advance determinations of coverage.—OBRA 90 would be modified with respect to treatment of potentially overused items. The Secretary would be able to develop and update a list of potentially overused items that the Secretary determines, on the basis of prior payment experience, are frequently subject to unnecessary utilization throughout a carrier's entire service area or a portion of such area. The Secretary would also be able to develop and periodically update a list of suppliers with respect to whom: (i) the Secretary has found that a substantial number of claims for payment for items furnished by the supplier have been denied; or (ii) the Secretary has identified a pattern of overutilization resulting from the business practice of the supplier. Payment for items on these lists would not be made unless the carrier has determined in advance whether an item is medically necessary and covered by Medicare. Carriers would also be required to make advance coverage decisions for customized items if requested by the supplier or beneficiary and to meet criteria developed by the Secretary to assure that advance coverage decisions are made on a timely basis.

(iii) Study in variations in durable medical equipment supplier costs.—The Secretary would be required to collect data on supplier costs for DME and analyze them to determine costs attributable to

service and product components and the extent to which they vary by type of equipment and geographic region. The HCFA Administrator would be required to submit a report and recommendations for a geographic cost adjustment index for DME supplies and an analysis of the impact of such an index on Medicare payments.

(iv) Oxygen retesting.—The OBRA 90 language regarding the arterial blood gas values would be amended to require retesting when a beneficiary's initial value is at or above 56.

(v) Other miscellaneous and technical amendments.—In addition, the proposal includes certain technical corrections to Sections 4152 and 4153 of OBRA 90.

Effective Dates.—Subsections (a), (b), (c), (e), (f), (g) and (h) would be effective sixty days after the date of enactment. Clauses (i), (iv), and (v) of subsection (i) would be effective as if included in the enactment of OBRA 90. Clause (ii) of subsection (i) would be effective six months after the date of enactment.

Sec. 28. Medicare Part B—Other Provisions

Present Law.—(a) Ambulatory surgical center services.—Current law requires the Secretary to update ambulatory surgery center payment rates by July 1, 1987 and annually thereafter, if the Secretary determines that an update is appropriate.

The OBRA 90 conferees also agreed to a provision providing for a process by which the fee for new technology intraocular lenses (IOLs) could be adjusted. Statutory language reflecting this agreement was inadvertently omitted from OBRA 90. OBRA 90 included a provision capping payments for IOLs at \$200 in 1991 and 1992. As drafted, the statutory language regarding IOLs could be interpreted as limiting payments for cataract surgery.

(b) Study of Medicare coverage of patient care costs.—OBRA 93 establish Medicare coverage of certain self-administered oral cancer drugs if they are the same chemical entity as anticancer drugs covered by Medicare when administered intravenously.

(c) Study of cap on amount of outpatient physical and occupational therapy services.—Outpatient physical and occupational therapy services are subject to an annual cap of \$900 when provided by independently practicing therapists.

(d) Part B premium payments late enrollment penalties by States.—Individuals who enroll in Medicare Part B after the applicable enrollment period are subject to an increased premium for late enrollment. The monthly premiums are increased by ten percent for every twelve months of late enrollment. In general, the premium increase is calculated based upon the number of months of delayed enrollment beyond the initial enrollment period. In the case of individuals who delay enrollment because they have primary coverage under an employer group health plan, months of enrollment in the employer group health plan are not included for purposes of calculating the increased premium.

States are permitted to pay premiums on behalf of individuals who enroll in Part B.

(e) Treatment of inpatients and provision of diagnostic and therapeutic x-ray services by rural health clinics and federally qualified health centers.—Rural health clinic (RHC) and Federally Qualified Health Center (FQHC) services are a covered benefit under Medi-

care. These entities that provide physician and other outpatient services are paid on the basis of an all-inclusive rate.

(f) Application of mammography certification requirements.—In 1992, the Congress enacted the Mammography Quality Standards Act which established a certification program for mammography facilities under Section 354 of the Public Health Service Act.

(g) Coverage of speech language pathologists and audiologists.—The services of speech therapists and audiologists are covered under certain limited circumstances. In addition, speech therapy is covered under the home health benefit. The law does not include a specific definition of these services or providers.

(h) Other technical amendments.—

(i) Revision of Information on Part B Claims.—Each Part B claim for which the entity submitting the claim knows or has reason to believe that there has been a referral by a physician must include the name and provider number of the referring physician and must indicate whether the referring physician is an investor in the entity.

(ii) Consultation for social workers.—OBRA 90 provided for direct reimbursement for the services of clinical psychologists and clinical social workers. The Secretary was required to develop criteria for psychologists' services under which psychologists would be required to consult with a patient's attending physician.

(iii) Reports on hospital outpatient payment.—OBRA 87 required the Prospective Payment Assessment Commission (ProPAC) to conduct a study of Medicare payment for hospital outpatient services. Part of the study was to be submitted to the Congress by July 1, 1990 and part by March 1, 1991. Section 1135(d)(6) of the Social Security Act also requires the Secretary to report to the Congress on the development of a prospective method for ambulatory surgery services.

(iv) Radiology and diagnostic services provided in hospital outpatient departments.—Payment for outpatient radiology and diagnostic services is limited to a blend of the hospital's costs and physician fee schedule that would apply if the procedure were performed in a physician's office.

(v) Payments to nurse practitioners in rural areas.—OBRA 90 provided for direct reimbursement of nurse practitioners and clinical nurse specialists in rural areas. While current law excludes the services of physician assistants, nurse midwives, certified registered nurse anesthetists, and psychologists from the definition of inpatient hospital care, payments for nurse practitioners and clinical nurse specialists were not included in this provision.

(vi) Other technical and conforming amendments.—Elderly or disabled employees and their spouses who are covered by employer health plans are not required to enroll in the same enrollment period applicable to others. However, they cannot enroll while enrolled in an employer group health plan. Coverage for such individuals begins generally on the first day of the month in which the individual is no longer enrolled in an employer group health plan. The OBRA 90 conferees intended to modify this provision, but statutory language to that effect was omitted from the law.

Explanation of Provision.—(a) Ambulatory surgical center services.—The update for ambulatory surgery services would be estab-

lished, beginning with fiscal year 1995, at the CPI-U for the twelve-month period ending with March of the preceding year. The Secretary would be required to conduct a survey, based on a representative sample of procedures and facilities, taken not later than January 1, 1995 and updated every five years thereafter, of the actual audited costs of ambulatory surgery facilities. The survey results would be used in establishing payment rates. The Secretary would be required to consult with appropriate trade and professional organizations in updating the list of procedures that can be performed in ambulatory surgery centers.

The Secretary would be required, within one year after the date of enactment, to develop and implement a process for reviewing reimbursement for new technology intraocular lenses (IOLs). In order to be considered a new technology IOL, the device would have to be approved by the FDA. The Secretary would also be required to consider specific circumstances in determining whether to adjust the payment amount for new technology IOLs. The provision also would specify the administrative procedures for reviewing and approving new technology IOLs.

In addition, certain technical and conforming amendments would be made to OBRA 90.

(b) Study of Medicare coverage of patient care costs.—The Secretary would study the costs of patient care for Medicare beneficiaries enrolled in clinical trials of new cancer therapies (where the protocol for the trial has been approved by the National Cancer Institute or meets similar scientific and ethical standards, including approval by an Institutional Review Board) and develop criteria for such coverage. The Secretary would submit a report on this study within two years of the date of enactment.

(c) Study of cap on amount of outpatient physical and occupational therapy services.—The Secretary would conduct a study of the costs associated with eliminating the cap on annual payments for the services of independent occupational and physical therapists. The Secretary would submit a report on this study by January 1, 1996.

(d) Part B premium penalty for late enrollment by states.—The Secretary would be authorized to enter into agreements with States for purposes of allowing States to make premium payments for penalties associated with late enrollment under Part B. States would be permitted to make quarterly payments on a lump-sum basis.

(e) Treatment of inpatients and provision of diagnostic and therapeutic x-ray services by rural health clinics and federally qualified health centers.—Coverage of RHC and FQHC services would be clarified as not being limited to outpatient services. Physician services, when providing to a patient of an RHC or FQHC who is an inpatient in a covered facility, would be covered and paid under the all-inclusive rate. In addition, diagnostic and therapeutic x-ray services would be covered as qualified RHC and FQHC services.

(f) Application of mammography certification requirements.—Any mammography facility providing covered screening or diagnostic mammograms to Medicare beneficiaries would be required to hold a certificate (or provisional certificate) issued in accordance with the provisions of the Public Health Service Act.

(g) Coverage of speech language pathologists and audiologists.—The definition of speech language pathologists and audiologists would be clarified and defined in law, consistent with current coverage practices.

(h) Other technical amendments.—

(i) Revision of information on Part B claims.—The claim form would be required to include the unique physician identification number (UPIN), and the requirement that claims indicate whether the referring physician is an investor in the entity would be repealed.

(ii) Consultation for social workers.—Clinical social workers would be required to consult with a patient's attending physician in the same manner as clinical psychologists.

(iii) Reports on hospital outpatient payment.—The requirement for the preparation of reports contained in Section 6137 of OBRA 89 and Section 1135(d)(6) of the Social Security Act would be repealed.

(iv) Radiology and diagnostic services provided in hospital outpatient department.—Outpatient payment limits would apply to diagnostic services. The physician component of the limit would be based on the resource based relative value scale.

(v) Payments to nurse practitioners in rural areas.—The services of nurse practitioners and clinical nurse specialists would be added to the list of services excluded from the definition of inpatient hospital services.

(vi) Other technical and conforming amendments.—The special enrollment period would be modified to allow individuals who have employer group health coverage to enroll in Part B at any time they are enrolled in the group health plan, rather than after they leave the plan. If an individual enrolls in Part B while enrolled in the group health plan or in the first month after leaving the plan, Medicare coverage would begin on the first day of the month in which the individual enrolled (or, at the option of the individual) on the first day of any of the following three months).

Various technical and conforming amendments to Sections 4154 through 4164 of OBRA 90 would be made.

Effective Date.—(a) Ambulatory surgical center services.—Except as otherwise provided, effective as if included in OBRA 90.

(b) Study of Medicare coverage of patient care costs.—Effective upon the date of enactment.

(c) Study of cap on amount of outpatient physical and occupational therapy services.—Effective upon the date of enactment.

(d) Part B premium penalty for late enrollment by States.—Effective upon the date of enactment.

(e) Treatment of inpatients and provision of diagnostic and therapeutic x-ray services by rural health clinics and federally qualified health centers.—Effective for services provided on or after January 1, 1995.

(f) Application of mammography certification requirements.—Effective for mammography furnished by a facility on and after the first date that the certificate requirements of section 356(b) of the Public Health Service Act apply to such services provided by such facility.

(g) Coverage of speech language pathologists and audiologists.—Effective upon the date of enactment.

(h) Other technical amendments.—Except as otherwise provided, effective as if included in OBRA 90.

Sec. 29. Medicare Parts A and B—Secondary Payer

Present Law.—The Department of HHS identifies Medicare secondary payer cases in the following ways: beneficiary questionnaires; provider identification of third party coverage when services are provided; Medicare contractor screening and data collection and exchange; and data transfers with other Federal and State agencies including the Internal Revenue Service and the Social Security Administration.

OBRA 93 provides for the establishment of a Medicare and Medicaid Data Bank to improve identification of secondary payer situations. Employers are required to submit health insurance information on coverage during calendar year 1994, beginning in February, 1995.

The Secretary is authorized to develop standards, criteria, procedures and reporting requirements to evaluate the performance of organizations facilitating Medicare payments to providers of services. Primary payers are required to make payments for any item or service for which Medicare is secondary payer when they receive notice that payments are due. The Secretary is authorized to charge interest on late recoveries under the Medicare Secondary Payer program.

Explanation of Provision.—The Administrator of HCFA would be required to mail questionnaires to individuals, before such individuals become entitled to benefits under part A or enroll in part B, to determine whether the individual is covered under a primary plan. In addition, the provision would clarify that payments would not be denied for covered services solely on the grounds that a beneficiary fails to complete the questionnaire.

Providers and suppliers would be required to complete information on claim forms regarding potential coverage under other plans.

Civil monetary penalties would be established for an entity that knowingly, willfully and repeatedly fails to complete a claim form with accurate information about the other available health plans.

Contractors would be required to submit a report to the Secretary annually regarding steps taken to recover mistaken payments. The Secretary would be required to evaluate the performance of contractors in recovering payments that should have been made by a primary plan.

The provision would clarify the Secretary's authority to charge interest if payment is not received within 60 days after notice is given.

A number of minor and technical corrections would be included.

Effective Date.—Effective six months following the date of enactment.

Sec. 30. Medicare Parts A and B—Other Provisions

Present Law.—(a) Definition of FMGEMS examination.—A graduate of a foreign medical school is not counted unless the resident

has passed parts I and II of the Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS).

(b) Qualified Medicare beneficiary outreach.—The Medicare Catastrophic Coverage Act of 1988 required States to pay Medicare premiums, deductibles and coinsurance for “Qualified Medicare Beneficiaries” (QMBs). QMBs are those Medicare beneficiaries whose family incomes are below 100 percent of the Federal poverty level and whose resources are no more than twice the amount allowed under SSI.

OBRA 90 accelerated the phase-in schedule for QMB coverage, and required States to pay premiums, but not other cost-sharing requirements for beneficiaries with incomes up to 110 percent of poverty by January 1, 1993, and to 120 percent of poverty by January 1, 1995.

Less than half of eligible beneficiaries are currently participating in the QMB program.

(c) Peer review organizations.—Peer Review Organizations (PROs) are required to precertify selected surgical procedures. PROs also are required to share certain information with State licensing boards.

(d) Health maintenance organizations.—The Omnibus Budget Reconciliation Act of 1990 required the Secretary to submit a proposal to the Congress by January 1, 1992, providing for a more accurate method of payment for HMOs paid on a risk basis. The Secretary was required to publish a proposed rule by March 1, 1992. The Comptroller General was required to review and report to the Congress by May 1, 1992 on recommendations to modify the proposed methodology. OBRA 90 also contained a number of minor and technical drafting errors.

(e) Home health agencies.—The limits for home health agencies are based upon the area wage index applicable to hospitals located in the geographic area in which the home health agency is located.

The waiver of liability for home health claims disallowed because of medical necessity expired as of November 1, 1990.

(f) Permanent extension of contracting authority on other than a cost basis.—Section 2326 of the Deficit Reduction Act of 1984, as amended by the Omnibus Budget Reconciliation Act of 1986 and the Omnibus Budget Reconciliation Act of 1989, provides authority to the Secretary to award contracts to fiscal intermediaries and carriers on other than a cost basis. This authority expired at the end of fiscal year 1993.

(g) Hospital agreements with organ procurement organizations.—Current law provides for Medicare payment of organ procurement costs incurred by designated organ procurement organizations (OPOs). OPOs are required to have agreements with hospitals to facilitate the identification of organ donors and to retrieve donated organs. Hospitals are required to notify OPOs of any potential organ donors.

(h) Technical correction to revise immunosuppressive drug therapy schedule.—Prior to OBRA 93, Medicare payments for immunosuppressive drug therapy for beneficiaries who received organ transplants was limited to one year following the date of a Medicare-covered transplant. OBRA 93 extended coverage for immunosuppressive drug therapy as follows: Effective January 1, 1995, cov-

erage will be extended to an 18-month period. Effective January 1, 1996, coverage will be extended to a 24-month period. Effective January 1, 1997, coverage will be extended to a 30-month period. Effective January 1, 1998, coverage will be extended to a 36-month period.

(i) Transportation demonstration project.—No provision.

(j) Diabetes demonstration project.—No provision.

(k) Expansion of the program of all-inclusive care for the elderly (PACE).—OBRA 86 required the Secretary to grant waivers of certain Medicare and Medicaid requirements to not more than 10 public or non-profit private community-based organizations to provide health and long-term care services on a capitated basis to frail elderly persons at risk of institutionalization. OBRA 90 expanded the numbers of organizations eligible for waivers to 15.

(l) Other technical amendments.—(i) Survey and certification requirements.—The Secretary is prohibited from imposing user fees on facilities for determining compliance with any requirement of Medicare. Current law could be interpreted to mean that user fees imposed pursuant to the Clinical Laboratory Improvement Act (CLIA) are prohibited.

(ii) Other technical amendments.—No provision.

Explanation of Provision.—(a) Definition of FMGEMS examination.—The Secretary would recognize the successor test to the Foreign Medical Graduate Examination in the Medical Sciences for the purpose of determining the eligibility of residents to be considered in determining payments for direct graduate medical education.

(b) Qualified Medicare beneficiary outreach.—The Secretary would be required to establish and implement a method for obtaining information from individuals when they become entitled to benefits under part A or enroll in part B that may be used to determine eligibility for benefits under the QMB program.

(c) Peer review organizations.—The requirement that PROs precertify selected surgical procedures would be repealed. The requirement for PROs to share information with State licensing boards would be modified. If the PRO finds, after a physician has received notice and had an opportunity for discussion, that a physician has furnished unnecessary or inappropriate services and that the physician should enter into a corrective action plan, the PRO would notify the State licensing board of its findings and of any action taken as a result of the findings.

(d) Health maintenance organizations.—The AAPCC payment methodology would be adjusted to take into account regional variations in the proportion of working aged for whom Medicare is a secondary payer. The Secretary would be required to revise the payment methodology for HMOs for contract years beginning with 1995 to take into account variation in costs associated with beneficiaries for whom Medicare is the secondary payer. The Secretary would be further required to submit a proposal to Congress by October 1, 1995 that provides for revisions to the payment methodology for contract years beginning with 1996. In proposing the revisions, the Secretary would be required to consider (i) the difference in costs associated with beneficiaries with different health status and (ii) the effects of using alternative geographic classifications. The Comptroller General would be required to report to the Con-

gress on the proposed revisions no later than three months after the Secretary's proposal was submitted.

(e) Home health agencies.—The most recent hospital wage data would be used in constructing the home health wage index for cost reporting periods beginning July 1, 1996. The waiver of liability provisions would be extended through December 31, 1995, consistent with the waiver extension under current law for skilled nursing facility and hospice services.

(f) Permanent extension of contracting authority on other than a cost basis.—Authority for the Secretary to enter into agreements with fiscal intermediaries and carriers on other than a cost basis would be made permanent.

(g) Hospital agreements with organ procurement organizations.—Hospitals would be required to enter into agreements with the OPO designated by the Secretary for the hospital's geographic area. The Secretary would be authorized to grant a waiver to allow a hospital to enter into an agreement with an OPO other than the one designated for the hospital's geographic area. The Secretary would be required to grant a waiver if the Secretary determines that the waiver is expected to increase organ donation, and that the waiver will assure equitable treatment of patients referred for transplants within the service area served by the hospital's designated OPO and within the service area served by the OPO with which the hospital or rural primary care hospital would enter into agreement under the waiver.

In making a decision whether to grant a waiver, the Secretary would be authorized to consider such factors as cost effectiveness, improvements in quality, whether there has been any change in a hospital's designated OPO due to a change made in the definitions for MSAs, and the length and continuity of a hospital's relationship with an OPO other than the hospital's designated OPO. The factors the Secretary could consider would not be construed as permitting the Secretary to grant a waiver that is not expected to increase organ donation or assure equitable treatment of patients.

Hospitals would be required to submit an application to the Secretary. The Secretary would be required to publish a public notice and seek public comment on any waiver application. Hospitals with existing agreements with OPOs other than the one designated for their area must submit an application for a waiver by January 1, 1995, and may continue existing agreements until a decision by the Secretary.

(h) Technical correction to revise immunosuppressive drug therapy schedule.—The provision would modify the phase-in schedule enacted in OBRA 93 for beneficiaries who receive immunosuppressive drugs following a Medicare-covered organ transplant. Individuals who receive a transplant prior to 1994 would be eligible for immunosuppressive drug coverage within 12 months following the date of the transplant. Individuals who receive a transplant during 1994 would be eligible for such drug coverage for 477 days after the date of enactment.

(i) Transportation demonstration project.—The Secretary would conduct a demonstration project at two sites, one in an urban area and one in a rural area to: (1) examine methods to reduce the cost of non-emergency medical transportation and regularly scheduled

medical transportation by coordinating the timing of non-emergency medical visits with the availability of public transportation, and (2) examine methods to reduce the cost of emergency medical transportation and emergency room treatment through the supervised use of ambulance emergency medical technicians.

(j) Diabetes demonstration project.—The Secretary would conduct a demonstration project to determine whether the manner in which Medicare pays for treatment of diabetes should be modified. Through demonstration projects in both urban and rural areas, the Secretary would provide for coverage of comprehensive diabetes treatment, management and education, including services necessary to provide intensive metabolic management found effective by the Diabetes Control and Complications Trial of the National Institutes of Health.

(k) Expansion of the program of all-inclusive care for the elderly (PACE).—The number of authorized PACE sites would be increased from 15 to 30.

(l) Other technical amendments.—(i) Survey and certification requirements.—The provision would clarify that user fees imposed under CLIA would not be subject to the general ban on user fees.

(ii) Other technical amendments.—Minor and technical amendments relating to Parts A and B of the Medicare program would be corrected.

Effective Date.—(a) would be effective as included if the Consolidated Omnibus Budget Reconciliation Act of 1995. (b), (c), (d), (e), (f), (h), (i), (j), (k) and (l) would be effective upon the date of enactment. (g) would be effective on and after January 1, 1995.

Sec. 31. Medicare Supplemental Policies

Present Law.—Section 1882 of the Social Security Act, as most recently amended by OBRA 90, provides for minimum standards for Medicare supplemental insurance (Medigap) policies.

(a) Preventing duplication.—The OBRA 90 amendments strengthen prohibitions against the sale of duplicative coverage to Medicare beneficiaries. The sale of a Medigap policy to an individual already covered under a Medigap policy is prohibited, as is, in general, the sale of a Medigap policy to a Medicaid beneficiary. Insurers are required to obtain written information from applicants regarding existing health insurance coverage.

The language also appears to prohibit the sale of any health benefits that duplicate any health coverage (including Medicare) to which a Medicare beneficiary is entitled.

(b) Loss ratios and refund of premiums.—The OBRA 90 amendments increased the minimum loss ratio standard for individual Medigap insurance policies from 60 percent to 65 percent. The standard is 75 percent for group policies. Policy issuers are required to provide a refund or credit against future premiums if needed to meet the loss ratio requirements.

(c) Pre-existing condition limitations.—The OBRA 90 amendments prohibit medical underwriting and certain other practices with respect to Medicare supplemental insurance policies for which an individual age 65 or older applies during the six month period beginning with the first month during which the individual is first enrolled for benefits under part B.

(d) Other miscellaneous and technical corrections.—The conference report to accompany OBRA 90 states the intent of the conferees that the National Association of Insurance Commissioners, in promulgating changes to the Model Medigap Regulations to conform with Federal requirements, would delete from section 12(C) all that follows “unless”, which is an exception to limitations on certain sales commissions. The OBRA 90 amendments also include a number of minor and technical drafting errors.

Explanation of Provision.—(a) Preventing duplication.—This provision would continue the current law prohibition on the sale of duplicative health insurance policies subject to the conditions described in the following paragraph. The provision would clarify that it is unlawful to sell or issue to an individual entitled to benefits under Part A or enrolled under Part B: (i) a health insurance policy with knowledge that such policy duplicates health benefits to which such an individual is otherwise entitled under Medicare or Medicaid; (ii) a Medigap policy with knowledge that the individual is entitled to benefits under another Medigap policy; and, (iii) a health insurance policy, other than a Medigap policy, with knowledge that such policy duplicates health benefits to which the individual is otherwise entitled.

Penalties would not apply, however, to the sale or issuance of a policy or plan that duplicates health benefits under Medicare or Medicaid or a policy or plan that duplicates health benefits to which the individual is otherwise entitled if, under the policy or plan, all benefits are fully payable directly to or on behalf of the individual without regard to other health benefit coverage of the individual. In addition, for the penalty to be waived in the case of the sale or issuance of a policy or plan that duplicates benefits under Medicare or Medicaid, the application for the policy must include a statement, prominently displayed, disclosing the extent to which benefits payable under the policy or plan duplicate Medicare benefits.

The statement would also include disclosure (after review by the Secretary) of the extent to which benefits payable under the policy duplicate benefits under the guaranteed national benefit package. This requirement would not apply, however, to policies listed in Title V as those specifically excluded from the duplication prohibition if they always pay without regard to other benefits. It would apply only to policies not so listed that do not pay benefits without regard to other coverage.

Policies that would be subject to the disclosure requirement include, but are not limited to: specific disease policies, hospital confinement indemnity policies, long term care policies, policies that provide fixed indemnity benefits for nursing home care, nursing services in the home or for home care, and policies that provide fixed indemnity benefits for any medical or surgical service or treatment.

The new provisions pertaining to non-duplication would not alter in any way the current law prohibition on the sale of a Medigap policy to a Medicaid beneficiary.

(b) Loss ratios and refund of premiums.—The provision would clarify that the OBRA 90 loss ratio standard would apply to policies sold or renewed after the effective date of the provision. With

respect to a refund or credit for policies issued prior to the effective date of the provision, the calculation would be based on aggregate benefits provided and premiums collected for all policies issued by an insurer in a state and based only on aggregate benefits provided and premiums collected under the policies after the effective date. Other minor and technical drafting errors would be corrected.

(c) Pre-existing condition limitations.—The provision would clarify the intent of OBRA 90 that, in the case of individuals enrolled in part B prior to age 65, Medigap insurers are required to offer coverage, regardless of medical history, for a six-month period when the individual reaches age 65. The provision would also clarify that insurers are prohibited from discriminating in the price of policies for such an individual, based upon the medical or health status of the policyholder.

(d) Other miscellaneous and technical corrections.—The provision would clarify that certain language should be deleted from section 12(C) of the National Association of Insurance Commissioners Model Regulations pertaining to sales commissions. The effective dates for various provisions would be modified. Other minor and technical drafting errors would be corrected.

Effective Date.—States would be required to adopt the Federal standards pertaining to provisions (a) and (b) effective for Medigap policies sold or issued beginning on January 1, 1997.

States in which the legislature was not scheduled to meet during calendar year 1996 would be required to adopt the standards effective for Medigap policies sold or issued beginning on January 1, 1998 or the first day of the first quarter after the close of the next scheduled meeting of the State legislature, whichever is earlier.

Provisions (c) and (d) would be effective upon the date of enactment.

Title IX. Quality and Consumer Protection

Subtitle A. Quality management and improvement

Sec. 1. National Quality Management Program

Present Law.—(a) National Quality Management Program.—The Peer Review Organization (PRO) was established to monitor the quality of care provided to Medicare patients to assure that services are medically necessary, provided in the appropriate setting, and meet professionally recognized standards of quality health care. PROs conduct certain utilization and quality-of-care reviews under contract with the Secretary. In response to identified problems, PROs are authorized to initiate a variety of interventions ranging from continuing education, denial of payments and other sanctions.

Although the principal focus of PRO review is inpatient hospital services, PRO responsibilities include review of ambulatory surgery, health maintenance organizations (HMOs), as well as some other non-hospital care.

(b) National measures of quality performance.—No provision.

(c) Consumer surveys.—No provision.

(d) Profiling health care providers.—No provision.

(e) Quality-related data.—No provision.

(f) National quality standards for health plans.—In general, Federal standards relating to quality assurance have not been established for health plans.

Under Medicare each contract with an eligible organization (i.e. health maintenance organization or competitive medical plan) must provide that the organization may not operate any physician incentive plan (as defined in section 1876(i)(8)(B) of the Social Security Act) unless the following requirements are met: (i) no specific payment is made directly or indirectly under the plan to a physician or a physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the organization; (ii) if the plan places a physician or a physician group at substantial financial risk as determined by the Secretary, for services not provided by the physician or physician group, the organization must provide stop-loss protection that is adequate and appropriate and conduct periodic surveys of current and former enrollees on degree of access to services and satisfaction with the quality of services; and (iii) upon request by the Secretary, the entity provides the Secretary with access to descriptive information regarding the plan, in order to permit the Secretary to determine whether the plan is in compliance with the physician incentive plan requirements of this section.

(g) Evaluating and reporting of quality performance.—No provision.

(h) Guideline development.—The Federal government has been supporting the development of practice guidelines since 1989. The Agency for Health Care Policy and Research (AHCPR) is funding the development of 16 guidelines at present, and may develop as many as 10 new guidelines per year. AHCPR has completed five guidelines including guidelines on pressure ulcers, urinary incontinence, acute pain management, benign prostatic hyperplasia, heart disease and management of cancer pain.

On April 6, 1987, HCFA published final regulations establishing criteria for Medicare coverage of heart transplants. For Medicare coverage purposes, heart transplants are medically reasonable and necessary when performed in facilities that meet certain criteria. Facilities that wish to obtain coverage for the Medicare patient are required to submit an application and documentation showing their initial and ongoing compliance with each of the criterion.

(i) Research on health care quality.—The Department of Health and Human Services conducts and supports general health services research, including research on medical effectiveness and outcomes.

Explanation of provision.—(a) National Quality Management Program.—The Secretary would establish and oversee a performance-based program of quality management and improvement designed to enhance the quality, appropriateness, and effectiveness of health care services rendered in the United States. The program would be known as the National Quality Management Program. The National Quality Management Program would be implemented by federally-qualified independent entities (known as Quality Improvement Organizations) through contracts with the Secretary of Health and Human Services, and by States through a grant program.

The Secretary would select, through a competitive process, no more than one Quality Improvement Organization to serve in each State, and may designate one organization to serve multiple contiguous States. Each contract would be awarded for a period of three years and would be renewable for an additional term of two years, based upon evidence of successful quality improvement performance without reopening the competitive selection process.

To be eligible for a contract under this section an organization would be required to be a private sector, not-for-profit entity whose governing board is broadly representative of consumers, purchasers of health care, health professionals, and representatives of academia. Each such organization would be required to be staffed by individuals with expertise in the field of quality improvement, epidemiology, patient outcome assessment, risk adjustment, clinical practice guidelines, health services data analysis, peer review, and provider and consumer education.

The Secretary would establish the criteria and procedures for approval of a contract. The Secretary would not enter into a contract unless the contract included assurances that the Quality Improvement Organization: (i) would be able to fulfill specified requirements that are set forth in the National Quality Management Program; (ii) would assist in the development of innovative patient education programs; (iii) would collaborate with, and provide technical assistance to, health plans and health professionals in ongoing efforts to improve quality of care; (iv) would conduct population-based monitoring of practice patterns; (v) would develop programs in lifetime learning; (vi) would disseminate information about quality management programs; and (vi) would maintain such records, make such reports, and cooperate with such audits as the Secretary finds necessary to determine compliance.

The Secretary would make grants to States to satisfy specified requirements that are set forth in the National Quality Management Program. To apply for a grant a State would submit an application in accordance with the procedures established by the Secretary. The Secretary would establish the criteria and procedures for approval of an application. The Secretary would not approve an application unless the application included assurances that the State: (i) would be able to fulfill the specified requirements in the National Quality Management Program; (ii) would maintain such records, make such reports, and cooperate with such audits as the Secretary finds necessary to determine compliance; and (iii) would only use funds received for consumer protection and quality oversight activities. The Secretary would periodically review the compliance of the State.

A State may satisfy any of the requirements under the National Quality Management Program directly or through arrangements with individuals or entities approved by the State. Such an individual or entity must: (i) demonstrate an ability to fulfill the duty delegated to the individual or entity by the State; and (ii) not have a financial interest in a health plan, institution or health care provider that would interfere with the ability to fulfill the duty.

The Secretary would assume the duties specified to be performed by the Quality Improvement Organizations if an organization was not available in a State or if an organization substantially failed

to satisfy a term of a contract. In the case of a State that does not receive a grant or that substantially failed to satisfy a term of an award, the Secretary would assume in the State the duties specified to be performed by the State.

Funding of \$300 million per year for each of the fiscal years 1997 through 2001 would be available for Quality Improvement Organizations and States for consumer protection and quality oversight efforts.

(b) National measures of quality performance.—The Secretary would develop and update a set of uniform national measures of quality performance. The measures would be used to assess the performance of health plans, institutions and health care professionals. The measures of quality performance also would be used by health plans to assess the satisfaction of their members' health status, and by consumers to assist in health plan selection. The measures could be based on guidelines developed or certified by the Administrator for Health Care Policy and Research, research sponsored by the Administrator or may incorporate standards identified by the Secretary as meeting public health objectives.

In developing and selecting national measures of quality performance, the Secretary would consult with a health care quality advisory commission. An eleven-member Commission would be appointed by the Secretary and would be composed of representatives from the private and public sectors with expertise in the fields of health care quality, and privacy of health information.

The Commission would provide recommendations to the Secretary with respect to the development and selection of national measures of quality performance, the establishment of an appropriate sequence for the interim sets of national measures of quality performance, and privacy of health information standards. In developing recommendations the Commission would consult with the Administrator for Health Care Policy and Research, States, health plans, health care providers, experts in quality measurement, private sector accrediting bodies, the National Association of Insurance Commissioners, appropriate Federal advisory bodies, and consumers of health care services.

The national measures of quality performance would be selected in a manner that provides accurate, comparable information on the following subjects: (i) access to health care services by enrollees; (ii) appropriateness of health care services provided to consumers; (iii) outcomes of health care services and procedures; (iv) patient functional status, patient satisfaction, and risk management and reduction; and (v) consumer satisfaction.

In developing and selecting national measures of quality performance the Secretary would use the following criteria: (i) the measures must be significant in terms of prevalence, morbidity, mortality or cost; (ii) the measures must be representative of the range of services provided to consumers; (iii) the measures must be reliable and valid; (iv) the data needed to calculate the measures must be obtained without undue burden on the entity or individual providing the data; (v) the measures must be limited to the minimum amount of information necessary to assess the performance of health plans, institutions, and health care professionals; (vi) the measures must take into account criteria appropriate to rural clini-

cal practice; and (vii) the measures would be linked to a health outcome based upon the best available scientific evidence.

The Secretary, upon the advice of the health care advisory commission, would define a sequence of implementation for the submission of information relating to the quality measures. Such information would initially include information on access to care, and a description of a plan's structural characteristics (i.e. data on the number, types and locations of health care providers). As reliable and valid data becomes available (as determined by the Secretary), and the system becomes fully operational additional data would be submitted.

Each health plan, and institution would be required to transmit to each State data necessary for the State to assess the performance of health plans, institutions, and health care professionals. The State would be required to transmit the results of such assessment to the quality improvement organizations. The quality improvement organizations would conduct such audits of the data submitted as are necessary to ensure that the data is valid, reliable, and complete. The quality improvement organizations would be required to publish and make available to the public a performance report outlining in a standard format the performance of each health plan, institution, and health care professional assessed on the national measures of quality performance. The report would include the results of consumer surveys. Any published report would be transmitted to the Secretary. The Secretary would compile such reports for the Congress.

(c) Consumer surveys.—The Secretary would develop and approve a standard design for consumer surveys to ensure the collection of valid, reliable and comparable survey responses. The Secretary would develop sampling strategies to ensure that survey samples adequately measure populations that are considered to be at risk of receiving inadequate health care. Health plans, and institutions would be required to conduct periodic surveys to gather information concerning access to care, use of health services, health outcomes, and patient satisfaction. A summary of the results of any survey would be forwarded to the States and included in the published report.

(d) Profiling health care providers.—The Secretary would adopt methodologies for profiling the patterns of practice of health care providers and for identifying outliers. An outlier would mean any health care provider whose pattern of practice suggests deficiencies in the quality of health care services being provided. The Secretary would disseminate the methodologies to the Quality Improvement Organizations, States, and health plans. The Secretary would develop standards for education with respect to outliers to assure quality.

The Quality Improvement Organizations would be required to implement the methodologies adopted and the standards established with respect to health care providers. The organizations would be responsible for ongoing, continuous external analysis and monitoring of community-wide patterns of clinical practice, through profiling, pattern analysis, and outlier identification for the purpose of promoting community based quality improvement.

It is expected that the Quality Improvement Organizations would work with and coordinate their activities with other not-for-profit private sector quality improvement organizations.

If the Quality Improvement Organization finds, after affording reasonable opportunities for improvement, that a provider, institution or health plan fails to engage in quality improvement activities or continues to furnish services of poor technical quality, the Quality Improvement Organization would be required to notify the appropriate federal and State boards or boards responsible for the licensing and discipline of providers and health plans. The Quality Improvement Organization would be required to issue a report annually to the Secretary on their findings.

(e) Quality-related data.—All health plans, institutions, and health care providers would be required to submit information to the quality improvement organizations, as provided by the Secretary, in order to enable quality review activities, and for practice parameters and outcomes analysis. The required information would be transmitted using a uniform electronic format established by the Secretary. The information required to be submitted would be developed consistent with the requirements under administrative simplification and would be required to use the least burdensome data collection method for data collection under this section.

(f) National quality standards for health plans.—Health plans would be required to meet standards established by the Secretary including standards to: (i) establish an internal quality assurance program; (ii) make available to enrollees information about their rights and responsibilities; (iii) provide an appeals procedure for review of benefit determinations; (iv) provide a grievance process that provides for effective and timely responses to complaints; (v) establish procedures for taking appropriate remedial action whenever inappropriate or substandard services are provided; (vi) verify the credentials of participating providers; (vii) establish a policy to identify and investigate sources of dissatisfaction, outline actions to follow up on the findings and inform providers of assessment results; (viii) give reasonable consideration to all certified professionals when selecting among providers in a provider network; and (ix) establish written policies and procedures to ensure that the confidentiality of health care information is protected.

The requirements relating to physician incentive plans as set forth in section 1876(i)(8)(A) and (B) of the Social Security Act would apply to all health plans. In addition, any managed care plan that places a physician or a physician group at substantial financial risk would be required to make available, upon request by enrollees, providers, or potential enrollees descriptive information on the financial arrangements in the physician incentive plan related to controlling utilization or costs.

The Secretary would develop rules to prohibit health insurers from engaging in any formal or informal practice including, but not limited to, the establishment of contract provisions, oral instructions, sanctions or protocols which would in any way restrict the provider or are intended to inhibit the provider from discussing with patients certain practices which may affect the patient's access to care. Those practices would include: (i) the compensation of the provider; (ii) a term of any contract between the insurer and

the provider; and (iii) practices, protocols, or patterns of applying utilization review procedures of the insurer. Such rules would be enforced with sanctions including civil monetary penalties of an amount not more than \$10,000 for each such violation.

(g) Evaluating and reporting of quality standards.—The States would be required to monitor periodically, but not less than annually compliance by health plans, institutions and providers with requirements applicable under the national quality management program.

If the State finds, after affording reasonable opportunities for improvement, that a provider, institution or health plan fails to engage in quality improvement activities or continues to furnish services of poor technical quality, the State would be required to enforce the requirements under this section by: (i) notifying the appropriate federal and State board or boards responsible for the licensing and disciplining of providers; (ii) prohibiting a health plan from providing coverage in the State; or (iii) imposing a civil monetary penalty.

(h) Guideline development.—The Secretary would establish a procedure by which individuals and entities would be able to submit guidelines to the Agency for Health Care Policy and Research (AHCPR) for evaluation and certification. The Secretary would direct AHCPR to establish and oversee a clearinghouse for dissemination of approved practice guidelines.

The Secretary would direct AHCPR to develop and annually update practice guidelines. The guidelines would be required to be based on reliable data, including data from outcomes research and clinical knowledge. The guidelines would be required to be based on data that demonstrates the degree to which a process of care increases the probability of desired patient outcomes.

The Secretary would direct AHCPR to develop guidelines for certain medical procedures designated by the Administrator to be performed only in tertiary care centers that meet certain criteria. Guidelines would be developed based on standards for frequency of procedure performance and intensity of support mechanisms that are consistent with the high probability of desired patient outcome. No payment under Medicare would be required to be made for such designated procedures which were in violation of the guidelines. The Secretary may exclude any person or entity from participation in Medicare if any person or entity provides such designated service that such person or entity knows or should know is in violation of this section.

The Secretary would establish a procedure for the development of separate pediatric practice guidelines for the medical treatment of children, and would be required to support research on outcomes of health care services and procedures provided specifically to children.

The Secretary, acting through the Agency for Health Care Policy and Research, would disseminate practice guidelines to Quality Improvement Organization, health care providers, States, and interested parties.

(I) Research on health care quality.—The Secretary would direct the Agency for Health Care Policy and Research (AHCPR) to support research, including research relating to: (i) outcomes of health

care services and procedures; (ii) effective and efficient dissemination of information, standards and guidelines; (iii) methods of measuring quality; and (iv) design and organization of quality of care components of automated health information systems. AHCPR would collect data from outcomes research and would disseminate any findings to the States, quality improvement organizations, health care providers and other interested parties.

A person who conducts biomedical or behavioral research involving human subjects, including clinical trials, would be prohibited from directly or indirectly receiving any funds under this Act if such person fails to comply with a guideline on the inclusion of women and minorities as subjects in clinical research established by the National Institutes of Health under the Public Health Service Act.

Funding would be reauthorized from the Medicare Trust Fund for the Agency for Health Care Policy and Research in the amount of \$6 million per year for each of the fiscal years 1995 through 2000. In addition, \$6 million per year for each of the fiscal years 1995 through 2000 would be authorized for health service research in the Department of Health and Human Services.

Effective Date.—The Secretary would be required to establish the standards not later than twelve months after the date of enactment. The provisions would be effective January 1, 1997. An exception would be provided for States in which the legislature was not scheduled to meet during calendar year 1996. These States would be given until January 1, 1998 to apply for a grant.

Sec. 2. Grievance and Appeals Process

Present Law.—Any individual dissatisfied with a decision relating to the amount Medicare will pay on a claim or whether services received are covered by Medicare, has the right to appeal the decision. Medicare is obligated to provide written notice of the decision made on a claim.

Explanation of Provision.—Health plans would be required to notify an enrollee of denial of payment, denial of services, termination or reduction in services. The health plan would be required to provide written notice within 30 days. The notice would be required to include: (i) language calculated to be understood by the typical enrollee; (ii) an explanation of the specific reasons and facts underlying the decision to deny, reduce or fail to provide services or pay the claim; and (iii) a description of the process for appealing such decision. If the health plan fails to notify an enrollee within 10 days, such failure would be treated as an approval by the plan.

An enrollee would have 60 days after receipt of notice of the denial, or termination or reduction of services to request in writing a reconsideration of the claim. The health plan would be required to complete any review and provide the enrollee notice of the plan's decision, within 30 days after receipt of the request for reconsideration. All reviews would be required to be done by an individual who did not make the initial decision denying the claim and who is authorized to approve the claim. The decision must be in writing, and set forth the specific reasons for the denial, including the medical basis for the determination.

Health plans would be required to provide for preauthorization of any claim submitted by an individual or a provider consisting of a request for preauthorization of items or services which are accompanied by an attestation that failure to immediately provide the items or services could reasonably be expected to result in: (i) placing the health of the individual claimant (or, with respect to an individual claimant who is a pregnant woman, the health of a woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part. A health plan would be required to make a determination within 24 hours after submission of a claim to the plan. Any claim which is denied may be filed in court without having to exhaust the remedies available under the health plan. For emergency care, no pre-authorization would be required.

Each State would be required to establish a review office pursuant to standards established by the Secretary. The State review office would be required to have appropriately trained individuals evaluating and deciding the cases. Any person who is aggrieved by any act or practice engaged in by a health plan which consists of or results in the denial of payment, denial of services or termination or reduction in services may file a complaint with the complaint review office. Such complaints may only be filed after the claimant has exhausted the remedies under the plan. Any decision made by a State review office would be non-binding, and nothing would prohibit an individual from seeking review through the judicial system.

A judicial review of a decision of a health plan or a State review office would be available at the claimant's option. A complaint may not be filed in a court of competent jurisdiction until the complainant has exhausted all remedies provided by the health plan with respect to denial of payment, denial of services or termination or reduction in services.

Effective Date.—January 1, 1997. An exception would be provided for States in which the legislature was not scheduled to meet during calendar year 1996. These States would be required to adopt the standards beginning on January 1, 1998.

Sec. 3. Additional Remedies and Enforcement Provisions

Present Law.—There is no comprehensive protection from discrimination against individuals with respect to the delivery of health care. There are a number of Federal laws which protect certain individuals against certain types of discriminatory action, including:

(i) The Equal Pay Act of 1963 which prohibits employers subject to the Fair Labor Standards Act from discriminating against employees on the basis of sex by paying differential wages;

(ii) section 4 of the Age Discrimination in Employment Act which generally prohibits employers from "discriminating against individuals with respect to compensation, terms, conditions, or privileges of employment because of such individuals' age;"

(iii) provisions of the Immigration Reform and Control Act which prohibits employers from discriminating against legal aliens or persons who appear foreign;

(iv) section 1981 of the Civil Rights Act of 1866 which prohibits employment discrimination based on race, alienage, and national origin;

(v) The Americans with Disabilities Act (ADA) which prohibits discrimination against a "qualified person with a disability;"

(vi) title VI of the Civil Rights Act of 1964 which generally prohibits recipients of Federal financial assistance from excluding persons from participation in or subjecting persons to discrimination under any Federally assisted program or activity because of such person's race, color or national origin; and

(vii) title IX of the Education Amendments of 1972 which prohibits discrimination based on sex by educational institutions receiving Federal financial assistance.

Explanation of Provision.—Any health plan, any health alliance, any State, or any health program or activity receiving federal financial assistance that engages in activity, either directly, indirectly or through contractual arrangements, that has the effect of discriminating against any individual on the basis of race, national origin, gender, age, religion, language, disability, sexual orientation, income, health status or anticipated need for health services would be liable to that individual or entity.

Any person may commence a civil action to obtain relief for violation. If the court finds that a violation has occurred, the court may grant compensatory and punitive damages, or injunctive relief and order such affirmative action as may be appropriate. The court may allow the prevailing party, other than the United States, reasonable costs, including attorney's fees and expert witness fees.

The Secretary of the U.S. Department of Health and Human Services would promulgate regulations that provide for the routine collection and reporting, by race, national origin, sex, language, income, age, and residence, to enable the Secretary to determine whether individuals and entities are complying with this section. The regulations would be required to ensure that any data collected under this section be collected using the least burdensome method. The Secretary would compile, analyze and make public the data collected under this section.

Effective Date.—January 1, 1996.

Sec. 4. Privacy of Information Standards for Protected Health Information

Present Law.—There is no consistent, comprehensive protection for privacy in health care information. At the Federal level there are a number of laws which protect certain types of information. The Privacy Act of 1974 protects individuals from Federal agencies' disclosure of confidential information. Provisions of the Social Security Act prohibit disclosure of information obtained by officers or employees of the Department of Health and Human Services. In addition, there is a Federal law which prescribes confidentiality requirements for records of patients who seek drug or alcohol treatment at federally funded facilities.

There are no Federal laws which define an individual's specific right to privacy in his or her personal health care information held in the private sector and by State and local government. There is

significant variation in the quality of State laws regarding privacy in health care information.

Explanation of Provision.—Standards would apply to any individual or entity who receives, collects, uses or maintains protected health information. Protected health information means any information in any form that identifies an individual and relates to the physical or mental health of the individual, the provision of health care to the individual, or payment for the provision of health care to the individual. Protected health information may only be used for the purpose for which the information was collected or received.

Any individual or entity may disclose protected health information if such use or disclosure is: (i) for the purpose of providing health care to an individual; (ii) for the purpose of providing for the payment for health care services for an individual; (iii) for use by a health oversight agency for a purpose authorized by law; (iv) for use in disease or injury reporting, public health surveillance, or public health investigations as legally authorized; (v) used to alleviate emergency circumstances affecting the health or safety of an individual; (vi) pursuant to the Federal Rules of Civil Procedure, the Federal Rules of Criminal Procedure, or comparable rules of other courts or administrative agencies; (vii) pursuant to a law requiring the reporting of specific medical information or child abuse or neglect information to law enforcement authorities; (viii) made to a law enforcement agency for the use in an investigation or prosecution as authorized by law; (ix) pursuant to a subpoena, summons or warrant; (x) for use in a health research project and quality assessment under the national quality and assurance program; and (xi) for use in licensing, accrediting or certifying health facilities or health professionals.

Protected health information may be disclosed to the next of kin or legal representative of the individual if the individual has not previously objected to the disclosure and the information disclosed relates to the ongoing provision of health care to the individual. A patient would have the right to inspect, copy and seek correction of protected health information. Information could only be withheld from the patient if the inspection or copying of the information would in the exercise of reasonable medical judgment cause sufficient harm to the individual or if the information identifies a confidential source.

The use or disclosure of protected health information would be limited to the minimum amount of information necessary to accomplish the purpose for which the information is used or disclosed. Nothing in this provision would require the disclosure of protected health information not otherwise required to be disclosed by law. All individuals and entities that use or disclose protected health information would be required to maintain reasonable and appropriate safeguards to ensure the integrity and confidentiality of protected health information.

The Secretary would develop standards with respect to protecting and shielding the identity of a patient. In developing these standards the Secretary would consult with the health care quality advisory commission. In developing recommendations, the Commission would be required to review all relevant information including

standards developed by the National Association of Insurance Commissioners.

Health information may be disclosed if a patient has signed a patient authorization form. The authorization form must specify the individual authorized to disclose such information, the person to whom the information is to be disclosed and the information to be disclosed. The Secretary would develop standards with respect to patient authorizations for disclosures that are in electronic form. The privacy of information standards would not apply to individuals who are casual recipients of health information.

Any individual who substantially fails to comply with the privacy of information standards would be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than \$10,000 for each such violation.

Any individual aggrieved by any act of an individual or entity in violation of this section may bring a civil action in the district court of the United States. The court may award actual damages and grant equitable relief. In an action where a complainant has prevailed because of a knowing violation, the court may award punitive damages and reasonable attorneys' fees and costs. No action may be brought unless such action is begun within two years from the date of the act complained of or the discovery of such an act.

Effective Date.—January 1, 1996.

Subtitle B. Information systems and administrative simplification

Sec. 5. Health Security Cards

Present Law.—No provision.

Explanation of Provision.—Each beneficiary of a qualified health plan, including Medicare and Medicare Part C would be issued a health security card. The card would be in a form similar to that of a credit card and would have information encoded in electronic form. The health security card would not become an identification document for purposes beyond the provision of health care.

Each card would include a universal health claims identification number, which would be the social security number of the beneficiary. In the case of an infant or other individual to whom such a number has not been issued, the Social Security number of the parent or guardian would be used as the identification number. The Secretary would establish standards with respect to the form and information to be contained on the cards. The card would contain information relating to organ donation. A civil money penalty of an amount not to exceed \$100 for each violation, would apply to plans which did not issue a health security card.

Effective Date.—The Secretary would first establish the standards for uniform health claims cards not later than eighteen months after the date of enactment. The provision would be effective twelve months after the date the standards are established by the Secretary.

Sec. 6. Requirement for Entitlement Verification System

Present Law.—The Omnibus Budget Reconciliation Act of 1993 provided for the establishment of a Medicare and Medicaid Cov-

erage Data Bank within the Department of Health and Human Services to ensure that employers (and other insuring entities) are primary payer, when Medicare and Medicaid should be secondary payer. Beginning February 28, 1995, employers with group health plans will be required to report to the Data Bank such information as the name and taxpayer identification number of the persons covered under the employer plan.

Explanation of Provision.—The Secretary would provide for an electronic system for the verification of an individual's enrollment in a qualified health plan, including Medicare and Medicare Part C and entitlement to benefits. The Secretary would establish standards respecting the requirements for certification of entitlement verification systems. The system would be required to be able to coordinate benefit information among health plans, Medicare and Medicare Part C.

Health plans subject to the verification requirements would be defined to exclude workers compensation and automobile insurance. The Secretary would establish standards with respect to the type of information that employers and health plans, including Medicare and Medicare Part C would be required to submit. Information reported would include: (i) name, address and Social Security number of the individuals enrolled; (ii) race and ethnicity data; (iii) name, address and identification number of the health plan elected; (iv) the type of coverage elected; (v) the period during which such coverage is elected; (vi) status of individuals with respect to deductibles, copayments and out-of-pocket limits; and (vii) coordination of benefit information appropriate in determining liability in cases in which benefits may be payable under two or more health plans. The information would have to be submitted periodically whenever eligibility for coverage changed. Any individual or entity that fails to provide enrollment information on a timely basis would be subject to civil monetary penalties not to exceed \$100 for each day in which such failure persists.

The enrollment verification system would be required to accept inquiries from health care providers, health plans, Medicare, Medicare Part C, and any other individual or entity determined appropriate by the Secretary. The system would be required to be capable of accepting inquiries in a variety of electronic and other forms including through the use of electronic card readers, touch-tone telephones, or computer modems.

The enrollment verification system would be required to respond to such inquiries in a variety of electronic and other forms, including modem transmission, computer synthesized voice communication and fax machine transmission.

The Secretary may impose a fee for the acceptance of, or responses to, an inquiry to the verification system.

In developing a system the Secretary would take into account the recommendations of private sector task forces, including the Workgroup on Electronic Data Interchange, the National Uniform Billing Committee, the Uniform Claim Task Force and national organizations representing healthcare financial managers.

The Secretary would develop public domain software which could be used by hospitals, physicians, and other providers to submit claims electronically to health plans.

Upon implementation of the eligibility verification system, the Medicare and Medicaid Coverage Data Bank, enacted in OBRA '93 would be repealed.

Effective Date.—The Secretary would establish the standards not later than twelve months after the date of enactment. The provision would be effective six months after the date the standards are established by the Secretary.

Sec. 7. Uniform Claims and Electronic Data Set

Present Law.—(a) Uniform claims formats.—No provision. However, uniform claims forms have been developed known as the UB-82 and UB-92 for hospital care, and the HCFA-1500 for physician services. Providers are required to use these forms in submitting claims to Medicare.

(b) Uniform coding of procedures and diagnoses.—The Omnibus Reconciliation Act of 1986 (OBRA '86) required fiscal intermediaries to require hospitals, as a condition of payment for outpatient services, to use the HCFA common procedure coding system. Physicians are required to use the ICDM-9 coding for diagnoses in submitting claims for payment.

(c) Unique provider identifier.—The Consolidated Omnibus Reconciliation Act of 1985 (COBRA) required the Secretary to develop a system of uniform provider identification numbers (UPINs) for use under the Medicare program.

(d) Public domain software.—No provision.

(e) Submission of claims to Medicare and Medicaid.—Medicare claims are submitted to fiscal intermediaries in the case of Part A claims, and carriers in the case of Part B claims. Fiscal intermediaries and carriers provide services under contract to the Secretary and are reimbursed for their costs with funds appropriated from the two Medicare trust funds.

(f) Clinical laboratory claims.—Medicare payment will be made only to the person or entity which performed or supervised the performance of such laboratory services.

Explanation of Provision.—(a) Uniform Claims Formats.—All claims submitted by providers would be transmitted using a uniform electronic format to be developed by the Secretary. The standards would relate to the form and manner of submission of claims and would define the data elements to be contained in a uniform electronic claims data set.

The electronic format would be required to be consistent with the standards for electronic claims developed by the American National Standards Institute and would be developed in consultation with various groups, including the Workgroup on Electronic Data Interchange, the National Uniform Billing Committee, the Uniform Claim Task Force and the Computer-based Patient Record Institute.

Health care providers and health plans, including Medicare and Medicare Part C would be required to use the uniform claim forms. A civil money penalty, not to exceed \$100 for each violation, would apply to plans and to providers, if they did not comply.

(b) Uniform coding of procedures and diagnoses.—The Secretary would develop a single, uniform coding system for procedures and diagnoses. In developing a uniform coding system for procedures

and diagnoses the Secretary would, to the maximum extent possible, use the current procedural terminology system (CPT-4 and the ICDM-9) with additional coding developed as necessary by the Secretary.

(c) Unique provider identifier.—Each provider, group practice and health plan would be required to submit claims using a unique provider identification number similar to the UPIN used for Medicare.

(d) Public domain software.—The Secretary would develop public domain software which could be used by hospitals, physicians, and other providers to submit claims electronically to health plans through the national health claims network.

(e) Submission of claims to Medicare.—Providers would submit claims to Medicare through the national health claims network (described below).

(f) Clinical laboratory claims.—Claims for clinical laboratory services would be required to be submitted directly by the person or entity that performed (or supervised the performance of) the tests to the plan in a manner consistent with the requirements for direct submission of such claims under the Medicare program.

Effective Date.—The Secretary would be required to provide for standards for uniform claims and would develop and make available the public domain software within eighteen months after the date of enactment. Providers would be required to submit claims using the standards six months after the standards were promulgated.

Sec. 8. Electronic Reporting

Present Law.—No provision.

Explanation of Provision.—The Secretary would promulgate standards for electronic reporting of uniform clinical data sets. The standards would include: (i) a definition of a uniform hospital clinical data set and a uniform patient information data set for claims adjudication and for quality review; (ii) a specification of, and manner of presentation of, the individual data elements; (iii) standards concerning the electronic transmission of such data sets; and (iv) standards relating to protecting the confidentiality and privacy of electronic data.

In establishing standards the Secretary would ensure that the development of such standards would be coordinated with the health care quality advisory commission, with the development of the standards for the uniform electronic claims data set. The development of these standards would be in consultation with the American National Standards Institute, hospitals, and health benefit plans. The standards for the uniform and electronic data set would be developed to the maximum extent practicable to be consistent with existing standards, including those set by the American National Standards Institute.

As a condition of Medicare participation, each hospital would be required to maintain hospital clinical data in electronic form in accordance with these standards. Each hospital would be required to transmit electronically data upon request of the Secretary, a utilization and quality control peer review organization or fiscal intermediary or carrier. A health plan may not require that a hos-

pital provide any data not in the uniform hospital clinical data set. The Secretary could grant waivers for rural and small community hospitals if the hospital could show that the requirement would cause financial hardship on the hospital.

State quill pen laws that require medical or health information to be maintained in written form would be preempted.

Effective Date.—The Secretary would establish the standards relating to a uniform hospital clinical data set and uniform patient information clinical data set prior to January 1, 2000. The provision concerning maintaining hospital clinical data in electronic form would be effective January 1, 2000.

Sec. 9. Uniform Hospital Reporting

Present Law.—The Omnibus Reconciliation Act of 1987 (OBRA '87) required the Secretary to establish a uniform hospital reporting demonstration project in two States. Under the demonstration, hospitals in Colorado and California are required to submit cost-reporting data based on a uniform hospital reporting format developed by the Secretary.

Explanation of Provision.—All Medicare-participating hospitals would be required to submit cost-reporting data based on regulations established by the Secretary.

Effective Date.—Hospitals would be required to report using the uniform hospital report for cost reporting periods beginning during or after FY 1995.

Subtitle C. National program to control fraud and abuse

Sec. 10. National Health Care Fraud and Abuse Program

Present Law.—(a) National Fraud and Abuse Program.—The Office of the Inspector General of the Department of Health and Human Services and the Attorney General are responsible for investigating and prosecuting health care fraud and abuse within the Medicare and Medicaid programs. The staff within the Office of the Inspector General (including investigators, auditors and analysts) are responsible for investigating and adjudicating fraud and abuse throughout the Department of Health and Human Services, including the Medicare and Medicaid programs. The Office of the Inspector General's budget in FY 1993 was \$100 million.

State agencies which are charged with administration of the Medicaid program also provide health care fraud control programs to restrict fraud and abuse within their agencies.

(b) Fraud and abuse account.—No provision.

Explanation of Provision.—(a) National Fraud and Abuse Program.—The Secretary of Health and Human Services (acting through the Inspector General of the Department of Health and Human Services) and the Attorney General would establish and coordinate an all-payer national health care fraud and abuse control program. The administration of the national program would include the coordination of the Medicare and Medicaid fraud and abuse programs.

To facilitate the enforcement of the all-payer health care fraud and abuse program, the Attorney General and the Inspector Gen-

eral would be authorized to conduct investigations, audits, evaluations and inspections relating to the delivery of and payment for health care, and to have access to all records available to health plans relating to the program.

In carrying out the program, the Secretary and the Attorney General would be required to consult with and arrange for the sharing of data with State law enforcement agencies, State Medicaid fraud control units, State agencies responsible for the licensing and certification of health care providers, health plans, and public and private third-party insurers.

All health plans, providers, and others would be required to cooperate with the national fraud control program and to provide necessary information for the investigation of fraud and abuse. The Secretary and the Attorney General would establish procedures to assure the confidentiality of the information required by the national fraud and abuse program and the privacy of individuals receiving health care services.

Health plans and providers would be required to disclose information that the Secretary and the Attorney General deem appropriate, including information relating to the ownership, control and management of a health care entity. In carrying out the duties and responsibilities under the program, the Inspector General and the Attorney General would be authorized to exercise all powers granted under the Inspector General Act of 1978 in the same manner and same extent as provided for in the Act.

Any individual or entity who fails to comply with a request of the Office of the Inspector General of the Department of Health and Human Services or the Attorney General for records, documents and other information necessary to carry out activities under the all-payer fraud and abuse control program may be excluded from participating in Medicare and State health care programs.

A qualified immunity (as specified in section 1157(a) of the Social Security Act) would be provided to persons providing information or communications to the Secretary or Attorney General under the health care fraud and abuse program.

The staff within the Office of the Inspector General of the Department of HHS would be increased to administer the national health care fraud control program. Appropriations would be authorized for additional amounts as may be necessary to enable the Secretary and the Attorney General to administer the national fraud and abuse program.

(b) Fraud and abuse account.—Any and all civil money penalties, fines, forfeitures and damages assessed in criminal, civil or administrative health care cases, along with any gifts and bequests would be deposited in an "All-payer Health Care Fraud and Abuse Control Account." The Account would be administered by a Board of Trustees which would be composed of the Secretary of Treasury, the Attorney General, the Secretary of Health and Human Services, the Inspector General and a State Attorney General. The Board of Trustees would be responsible for allocating and dispensing funds in the Account. The assets in the account would be used to meet the operating costs of the national health care fraud and abuse control program and for such activities that are designed to educate providers about the fraud and abuse provisions.

Effective Date.—January 1, 1996.

Sec. 11. Anti-kickback Statutory Provision

Present Law.—(a) Anti-kickback statutory provisions.—Individuals who knowingly and willfully solicit, receive, offer, or pay any remuneration, including any kickback, bribe, or rebate in return for referring or inducing an individual to receive a covered benefit under Medicare, or in return for purchasing, leasing, ordering or arranging for any good, facility, service or item for which payment may be made under Medicare is guilty of a felony and shall be fined not more than \$25,000, imprisoned for not more than five years, or both.

(b) Anti-kickback exceptions.—Five exceptions exist for kickback violations. The anti-kickback provisions do not apply to the following: (i) a discount or other reduction in price obtained by a provider of services or other entity under Medicare or a State health care program if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under Medicare or a State health care program; (ii) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services; (iii) any amount paid by a vendor of goods or services to a person authorized to act as a purchasing agent for a group of individuals or entities under specified conditions; (iv) a waiver of any coinsurance under Part B of Medicare by a Federally qualified health care center with respect to an individual who qualifies for subsidized services under a provision of the Public Health Service Act; and (v) any payment amount specified by the Secretary in regulations.

Explanation of Provision.—(a) Anti-kickback statutory provisions.—An intermediate civil monetary penalty of up to \$50,000 per violation would be established for anti-kickback violations. The current criminal fine would be increased to no more than \$50,000. An assessment of three times the total amount of remuneration offered, paid, solicited or received, would be established as an additional sanction for both civil and criminal violations.

A kickback violation would exist if a person knowingly and willfully solicits, receives, offers or pays any remuneration, including kickbacks, bribes or rebates to refer an individual to receive a covered benefit under Medicare or Medicaid. A kickback violation would exist if one or more purposes of the remuneration were unlawful.

(b) Anti-kickback exceptions.—The current exception for discounts would be modified to prevent a provider of services from giving discounts in the form of a cash payment. The current exception for bona fide employment relationships would be modified to require that any remuneration be consistent with fair market value, and not be determined in a manner that takes into account the volume or value of any referral. The exception would also be modified to allow employees to be paid remuneration in the form of a productivity bonus based on services personally performed by the employee.

The current exception for waiver or reduction of coinsurance would be modified to allow for such arrangements if: (i) the waiver

or reduction of coinsurance is made pursuant to a public schedule of discounts which the person is obligated as a matter of law to apply; (ii) the waiver or reduction of coinsurance is not offered as part of any advertisement or solicitation and the person determines in good faith that the individual is in financial need; (iii) the waiver or reduction of coinsurance is made pursuant to an established program, and applies to a defined group of individuals whose incomes do not exceed 150 percent of poverty (or such higher percentage as the Secretary may permit); (iv) the person fails to collect coinsurance or deductible amounts after making reasonable collection efforts; or (v) the waiver or reduction of coinsurance is pursuant to cost sharing schedules or supplemental benefits established for managed care plans under this Act.

A new exception would be provided for any reduction in cost sharing or increased benefits given to an individual, any amounts paid to a provider of services for items or services furnished to an individual, or any discounts or reductions in price given by the provider for such items or services, if the individual is enrolled with a health plan that is: (i) furnishing items and services under a risk-sharing contract under section 1876 or 1903(m); or (ii) receiving payments on a prepaid basis, under a demonstration project under section 402(a) of the Social Security Amendments of 1967 or under section 222(a) of the Social Security Amendments of 1972.

A new exception would be provided for any amounts paid to a provider of services for items or services furnished to an individual, or any discounts or reductions in price given by the provider for such items or services, if the items or services furnished by a physician or provider are included in the services for which a physician or provider is paid only on a capitated basis by a health plan pursuant to a written arrangement and in which the physician or provider assumes financial risk for those services.

The Secretary would be authorized to impose by regulation such other requirements as needed to protect against program or patient abuse.

Effective Date.—January 1, 1996.

Sec. 12. Civil Monetary Penalty Statutory Provisions

Present Law.—Civil money penalties may be imposed for each fraudulent claim for reimbursement under the Medicare and Medicaid programs. In addition, twice the amount claimed may be assessed against the fraudulent party.

The violations which are subject to civil money penalties under the Medicare and Medicaid programs include: (i) submitting claims for items or services not provided or which were false or fraudulent; (ii) submitting claims for services by someone who was not a licensed physician, whose license was obtained through misrepresentation, or who misrepresented his or her qualification as a specialist; and (iii) providing items or services by an excluded practitioner.

Civil money penalties may also be imposed on a hospital who knowingly makes a payment to a physician, or a physician who knowingly accepts payment from a hospital as inducement to limit or reduce care to a Medicare or Medicaid patient.

Persons liable for civil money penalties are given an opportunity for a hearing, for a discretionary appeal to the Secretary, and for judicial review in the U.S. Court of Appeals.

Explanation of Provision.—A civil monetary penalty would be established for the following additional types of improper conduct: (i) offering inducements to individuals under the Medicare or Medicaid program that such person knows or should know are likely to induce the individual to receive an item or service from a particular provider, except that a managed care plan may provide benefits to enrollees to encourage compliance with established practice patterns of medically necessary service; (ii) engaging in a practice which has the effect of limiting or discouraging the utilization of medically necessary services; (iii) substantially failing to cooperate with a quality assurance program or a utilization review activity; and (iv) submitting false or fraudulent statements to any Federal or State agency relating to the national health care program.

A health plan that substantially fails (defined as a “pattern of practice”) to provide or authorize medically necessary items or services that are required to be provided under the health plan, if the failure has adversely affected (or had a substantial likelihood of adversely affecting) the individuals, would also be subject to a civil monetary penalty.

An exception would be provided for the waiver or reduction of coinsurance if: (i) the waiver or reduction of coinsurance is made pursuant to a public schedule of discounts which the person is obligated as a matter of law to apply; (ii) the waiver or reduction of coinsurance is not offered as part of any advertisement or solicitation, and the person determines in good faith that the individual is in financial need; (iii) the waiver or reduction of coinsurance is made pursuant to an established program, and applies to a defined group of individuals whose incomes do not exceed 150 percent of poverty (or such higher percentage as the Secretary may permit); (iv) the person fails to collect coinsurance or deductible amounts after making reasonable collection efforts; or (v) the waiver or reduction of coinsurance is pursuant to cost sharing schedules or supplemental benefits established for managed care plans under this Act.

Civil monetary penalties would be increased to no more than \$10,000 for each false or improper item or service. The assessment would be increased to three times the amount claimed and interest would accrue on the penalties and assessments after a final decision.

If within one year of presentment of a case, the Attorney General does not initiate a criminal or civil action, the Secretary would be able to initiate a civil monetary penalty proceeding.

Effective Date.—January 1, 1996.

Sec. 13. Application of Civil Money Statutory Penalties to All-payers

Present Law.—No provision.

Explanation of Provision.—In general, the provisions under the Medicare and Medicaid programs which provide for civil money penalties for specified fraud and abuse violations (as amended) would apply to similar violations for all payers in the national health care system.

The following activities would be prohibited for all payers and would result in civil monetary penalty not to exceed \$10,000: (i) terminating or refusing to re-enroll an individual in violation of federal standards for health plans or State law; (ii) engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment in a health plan on the basis of a medical condition; (iii) engaging in any practice to induce enrollment in a health plan through representations which the person knows or should know are false or fraudulent.

Civil monetary penalties would be no more than \$10,000 for each false or improper item or service. The assessment would be three times the amount claimed and interest would accrue on the penalties and assessments after a final decision.

If within one year the Attorney General does not initiate a criminal or civil action, the Secretary could initiate a civil monetary penalty proceeding.

Effective Date.—January 1, 1996.

Sec. 14. Private Right of Action

Present Law.—No provision.

Explanation of Provision.—A health plan, including a sponsor of a self-insured health plan that suffers financial harm based upon the submission of claims for health care items or services by an individual or entity, which makes the individual or entity subject to a civil monetary penalty may bring a civil action in the United States District Court.

A health plan would be required to provide the Attorney General and the Secretary with written notice of the health plan's intent to bring an action, the identities of the individuals or entities the health plan intends to name as defendants to the action, and all information the health plan possesses regarding the action. A health plan may bring an action, if after the expiration of a sixty-day period, neither the Attorney General, nor the Secretary, notifies the health plan that they intend to pursue a civil monetary penalty.

If after one year, the Secretary has not proceeded with reasonable due diligence in the matter, the health plan may proceed with an action. If the Secretary proceeds with the action, the health plan may receive an amount the Secretary decides is appropriate restitution. If the Secretary does not proceed with an action, ten percent of the proceeds of the action or settlement of a claim would be deposited in the anti-fraud and abuse account. No action may be brought more than six years after the date of the activity with respect to which the action is brought.

Effective Date.—January 1, 1996.

Sec. 15. Amendments to Exclusion Provisions in Fraud and Abuse Program

Present Law.—Section 1128 of the Social Security Act authorizes the Secretary to impose mandatory and permissive exclusions from Medicare and State health care programs. In the case of an exclusion under the mandatory exclusion authority the minimum period of exclusion could be no less than five years, except the Secretary

may waive the exclusion in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community.

Explanation of Provision.—The Secretary would have the additional mandatory exclusion authority to exclude individuals and entities based on felony convictions relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of a health care item or service. This provision would only apply to individuals and entities who are subject to a felony conviction arising from activities conducted on or after January 1, 1996.

Minimum periods of exclusion for certain violations already specified in statute would be established. In the case of an exclusion of an individual or entity for a misdemeanor conviction relating to fraud, the period of the exclusion would be three years unless the Secretary determines based on aggravating or mitigating factors that a shorter or longer period is more appropriate.

In the case of an exclusion of an individual or entity relating to obstruction of an investigation or the unlawful manufacture, distribution, prescription or dispensing of a controlled substance, the period of the exclusion would be three years unless the Secretary determines based on aggravating or mitigating circumstances that a shorter or longer period is more appropriate.

In the case of license revocation or suspension under a Federal or State health care program, the exclusion would be no less than the period during which the individual's license to provide health care is revoked or the individual is excluded from a program.

In the case of an exclusion for filing claims for excessive charges or unnecessary services and failure to furnish medically necessary services the minimum period of exclusion would be one year.

The minimum period of exclusion for practitioners failing to meet quality of care obligations would be one year.

Effective Date.—January 1, 1996.

Sec. 16. Amendments to Quality of Care Sanctions

Present Law.—(a) Civil monetary penalties.—The Secretary may require the payment of civil money penalties in lieu of program exclusion in cases where the practitioner or person has provided health care services which were medically improper or unnecessary. The amount is limited to the actual or estimated cost of the medically improper or unnecessary services.

(b) Deletion of willing and able test for physician sanctions.—If a PRO determines that a practitioner has failed in a substantial number of cases substantially to provide services that are necessary, appropriate and of a quality that meets professionally recognized standards of care, or if said practitioner grossly and flagrantly violates any of those obligations in one or more instances, the PRO shall submit a report and recommendations to the Secretary.

If the Secretary agrees with the PRO's determination, and determines that a practitioner has demonstrated an unwillingness or a lack of ability substantially to comply with the PRO quality of care obligations, the Secretary (in addition to any other sanction provided) may exclude the practitioner from participating in Medicare.

The practitioners who are dissatisfied with a determination made by the Secretary are entitled to reasonable notice and opportunity for a hearing, and judicial review of the Secretary's final decision.

Explanation of Provision.—(a) Civil Monetary penalties.—Practitioners or persons who violate quality of care obligations as determined by the Peer Review Organization would be subject to a civil monetary penalty of not more than \$10,000 as an alternative to program exclusion.

(b) Deletion of willing and able test for physician sanction.—The additional requirement that the practitioner be shown to be “unwilling or unable” to meet PRO quality of care obligations before the Secretary may exclude the individual from participating in Medicare would be deleted.

Effective Date.—January 1, 1996.

Sec. 17. Application of Criminal Penalties to All Payers

Present Law.—Criminal penalties may be imposed against individuals under the Medicare or Medicaid program who: (i) knowingly and willfully make or cause to be made a false statement in any application for any Medicare benefit or payment; (ii) knowingly and willfully make or cause to be made a false statement for use in determining rights to such a benefit or payment under Medicare or Medicaid; (iii) knowingly conceal information with an intent to fraudulently secure the benefits not due; (iv) knowingly convert benefits to a use other than for the use and benefit of the other person; and (v) present a claim knowing that the physician who furnished the services was not licensed as a physician.

The above acts constitute a felony if committed by a person who furnishes items or services for which payment is or may be made under Medicare or Medicaid.

It is also a felony to knowingly solicit, receive or offer kickbacks, bribes or rebates in return for referral of services and to solicit, accept, charge or receive any amounts as a precondition for admitting a Medicaid patient.

Explanation of Provision.—In general, the provisions under the Medicare or Medicaid program which provide for criminal penalties for specified fraud and abuse violations would apply to similar violations relating to other payers in the national health care system. Violations specifically tailored to the Medicare and Medicaid programs would not, however, constitute violations under the all-payer fraud and abuse control program.

The assessment would be increased to three times the amount claimed. The Secretary would, in consultation with State and local health care officials, identify opportunities for the satisfaction of community service obligations that a court may impose upon the conviction of an offense under this section.

Effective Date.—January 1, 1996.

Sec. 18. Corporate Practice of Medicine Laws

Present Law.—State Corporate Practice of Medicine Laws in several States prohibit a corporation from practicing medicine. This proscription includes general corporate ownership of a clinic where treatment is performed by licensed physicians who are employed by

the corporation. A corporation, not being a natural person, cannot be licensed, and therefore may not practice medicine.

Explanation of Provision.—State Corporate Practice of Medicine Laws that prohibit a corporation from practicing medicine would be preempted.

Effective Date.—January 1, 1996.

Sec. 19. Advisory Opinions

Present Law.—No provision.

Explanation of Provision.—The Secretary of Health and Human Services (in consultation with the Attorney General) would be required to issue advisory opinions on the following matters: (i) the anti-kickback statute (section 1128B(b) of the Social Security Act); and (ii) the physician ownership and referral statute (section 1877 of the Social Security Act). Advisory opinions would be limited to the facts presented in the request for an advisory opinion.

The Secretary would issue regulations that are appropriate to carry out this part, including regulations concerning: (i) the process under which individuals and entities submit requests for advisory opinions; and (ii) the process under which the Secretary responds to requests for advisory opinions. Any and all fees would be deposited in the All-payor Health Care Fraud and Abuse Control Account.

The Secretary of Health and Human Services and the Attorney General would have one year from the date of enactment of the legislation to initiate the advisory opinion process.

The Secretary would be required to respond to a request within 90 days of receipt of a request.

Individuals and entities requesting an advisory opinion would be required to pay an amount sufficient to cover 100 percent of the costs incurred by the Department of Health and Human Services and the Attorney General in rendering opinions.

Effective Date.—One year from the date of enactment.

Subtitle D. Physician ownership and referral

Sec. 20. Expansion of Medicare Ban on Self-referrals

Present Law.—Physicians (or immediate family members of such physicians) with a financial relationship with clinical laboratories are prohibited from referring Medicare patients to those entities. The entity may not present or cause to be presented a claim under Medicare or bill to any individual, third party payer, or other entity for clinical laboratory services furnished pursuant to a prohibited referral.

OBRA '93 specifies that beginning January 1, 1995 the referral ban would apply to Medicaid and would extend to the following designated health services: (i) clinical laboratory services; (ii) physical or occupational therapy services; (iii) radiology or other diagnostic services; (iv) radiation therapy services; (v) durable medical equipment; (vi) parenteral and enteral nutrients, supplies, and equipment; (vii) prosthetics, orthotics, and prosthetic devices; (viii) home health services; (ix) outpatient prescription drugs; and (x) inpatient and outpatient hospital services.

Explanation of Provision.—The Medicare and Medicaid ban would apply to all payers for designated health services. No payment could be made under Medicare, another Federal health care program, a State health care program or a private health plan for which a claim was presented in violation of the ban. The entity or the physician could not present or cause to be presented a claim under Medicare or Medicaid or bill to any individual, third party payer, or other entity for designated health services furnished pursuant to a prohibited referral. Sanction provisions would be extended to all payers.

Effective Date.—January 1, 1996.

Sec. 21. Extension of Self-referral Ban to Additional Services

Present Law.—OBRA '89 established a ban, effective January 1, 1992, on certain financial arrangements between referring physicians and clinical laboratories. OBRA '93 expanded the current law to cover "designated health services".

Designated health services include: (i) clinical laboratory services; (ii) physical or occupational therapy services; (iii) radiology or other diagnostic services; (iv) radiation therapy services; (v) durable medical equipment; (vi) parenteral and enteral nutrients, supplies, and equipment; (vii) prosthetics, orthotics, and prosthetic devices; (viii) home health services; (ix) outpatient prescription drugs; and (x) inpatient and outpatient hospital services.

Explanation of Provision.—Other diagnostic services would be deleted from the list of designated health services subject to the physician referral ban. The list of designated health services under the physician ownership and referral ban would be extended to cover home infusion therapy (excluding infusion pumps) and any other item or service not rendered by the physician personally or by a person under the physician's direct supervision.

Effective Date.—January 1, 1996.

Sec. 22. Exceptions for Both Ownership and Compensation Arrangements

Present Law.—(a) Physician services.—An exception exists for physicians' services provided by (or under the personal supervision of) the physician or another physician in the same group practice.

(b) In-office ancillary services.—An exception exists for in-office ancillary services. In-office ancillary services are defined as services furnished by the physician himself, another physician in the same group practice, or individuals directly supervised by the physician or the physician's group practice.

The current exception applies to clinical laboratory services. Effective January 1, 1995, the exception would apply to all designated health services except durable medical equipment (excluding infusion pumps) and parenteral and enteral nutrients, equipment and supplies.

To be exempted from the referral ban, the services must be provided in a building in which the physician or other member of the group practice provides services unrelated to the designated service, or in a central building set up by the group to perform the group's designated services (other than clinical laboratory services).

The services must be billed by the physician performing or supervising the services, or by that physician's group under a billing number assigned to the group practice, or by an entity entirely owned by the physician or group practice.

(c) Prepaid plans.—An exemption exists for services furnished by an organization: (i) with a contract under section 1876 of the Social Security Act; (ii) described in section 1833(a)(1)(A) of the Social Security Act; or (iii) receiving payments under certain demonstration projects. OBRA '93 added federally-qualified health maintenance organizations to the definition.

(d) Shared facilities.—Current law does not contain a general exemption for this type of arrangement.

Explanation of Provision.—(a) Physician services.—The exception for physicians' services would be repealed.

(b) In-office ancillary services.—The in-office ancillary service exception would be modified to separate the provisions related to solo practitioners from those for group practices. In addition to the general requirements, solo practitioners would be required to furnish designated health services: (i) on equipment that is wholly owned or exclusively leased by the referring physician; and (ii) in an office location in which the referring physician furnishes physician services unrelated to the furnishing of the designated health service. The designated health services would be required to be furnished by the referring physician or personally by individuals who are directly supervised by the physician.

The current standards used to define a group practice would be revised. The group would be required to own or exclusively lease, in the name of the group, space or equipment used in the furnishing of the group's services, including designated health services to patients of the group. No member of the group would be allowed to personally employ others who participate in the furnishing of services to patients of the group.

No member of the group would be allowed to separately on the member's own behalf, enter into arrangements with any type of managed care entity (including health maintenance organizations and preferred provider organizations), third party payers or any other health benefit plan for the provision of services to patients of the group. A group practice would be allowed to have an arrangement with a managed care entity, payer, or plan which applies to some but not all the members. This prohibition would not preclude physicians who are forming or joining a group practice from fulfilling the terms of preexisting arrangements, provided that such arrangements are terminated as soon as is permissible within the terms of the arrangements and provided that any revenue generated from such arrangements become the revenue of the group practice.

The group would be required to have a governing body or persons with responsibility for the conduct of the group practice, including: (i) making decisions relating to retention of all physician and nonphysician personnel; (ii) promulgating and enforcing personnel policies; (iii) development of salary, bonus, and benefits applicable to physicians and physician personnel; and (iv) establishment of fees for all services furnished by the group. The governance and

employment practices could be delegated within a group and would not be required to be in writing.

The employment practices of the group practice would be required to be established by the group and be applicable to all employees of the group.

(c) Prepaid plans.—An exception would be provided in the case of a designated health service, if the designated health service is included in the services for which a physician or physician group is paid only on a capitated basis by a health plan pursuant to a written arrangement and in which the physician or physician group assumes financial risk for those services.

(d) Shared facilities.—An exception would be provided for shared facility services that are furnished: (i) personally by the referring physician who is a shared facility physician or by an individual directly employed by such a physician; (ii) by a shared facility in a building in which the referring physician furnishes substantially all of the services of the physician unrelated to the furnishing of shared facility services; and (iii) to a patient of a shared facility physician. The shared facility services would be required to be billed by the referring physician.

Effective Date.—January 1, 1996.

Sec. 23. Exceptions Related Only to Ownership or Investment

Present Law.—(a) Publicly traded securities.—There is a specific exception for ownership of investment securities which may be purchased on terms generally available to the public. Prior to 1995, these securities are defined as those purchased in a corporation listed on a major stock exchange (New York, American) or traded under an automated interdealer quotation system operated by the National Association of Securities Dealers. The corporation must have total assets exceeding \$100 million at the end of the corporation's most recent fiscal year.

OBRA '93 specifies that beginning in 1995, the definition would be modified to include securities which are listed for trading on a regional exchange or a foreign exchange. The exception would be further modified to apply to a corporation with stockholder equity in excess of \$75 million, either at the end of its most recent fiscal year or on an average during the previous three fiscal years. The exception would also be modified to include ownership of shares in a regulated investment company, provided the company has total assets of over \$75 million over the same time period.

(b) Rural providers.—An exception exists for designated health services furnished by an entity in a rural area (as defined for purposes of Medicare's hospital prospective payment system). OBRA '93 modifies the definition, effective beginning in 1995, to apply only if substantially all the designated health services furnished by such entity are furnished to individuals residing in the rural area.

Explanation of Provision.—(a) Publicly traded securities.—The publicly traded securities exception would be modified to require that at the time the security was acquired by the physician, the security could have been purchased on terms generally available to the public.

(b) Rural providers.—The current exception for rural providers would be clarified to exempt entities providing 75% of their services to rural residents.

Effective Date.—January 1, 1996.

Sec. 24. Exceptions Related Only to Compensation Arrangements

Present Law.—The law includes an exception for remuneration which is provided by a hospital to a physician if such remuneration does not relate to the provision of designated health services.

Explanation of Provisions.—The exception for remuneration unrelated to the provision of designated health services would be repealed.

Effective Date.—January 1, 1996.

Sec. 25. Referring Physicians

Present Law.—Requests by a pathologist for clinical diagnostic laboratory tests and pathological examination services, a radiologist for diagnostic services for diagnostic radiology services and a radiation oncologist for radiation therapy would not constitute a referral by a referring physician if such services are furnished by (or under the supervision of) such pathologist, radiologist, or radiation oncologist pursuant to a consultation requested by another physician.

Explanation of Provision.—An additional exception would be provided for requests by nephrologists for any item or service related to renal dialysis.

Effective Date.—Effective as if included in OBRA '93.

Sec. 26. Miscellaneous and Technical Provisions

Present Law.—(a) Financial relationship.—A financial relationship is defined as including an ownership or investment interest in the entity or a compensation arrangement between the physician (or immediate family member) and the entity. An ownership or investment interest may be through equity, debt, or other means. Effective January 1, 1995, an ownership or investment interest would include an interest in an entity (i.e., holding company) that holds an investment or ownership interest in another entity.

(b) Payment by a physician.—An exception is provided for payments by a physician to an entity as compensation for an item or service, if the item or service is furnished at a price that is consistent with the fair market value. An exception is provided for payments by a physician to a clinical laboratory in exchange for the provision of clinical laboratory services.

(c) Reporting requirements.—Each entity providing covered items or services under Medicare is required to report to the Secretary certain information concerning the entity's ownership arrangement.

(d) Effective dates.—Some of the OBRA '93 provisions apply to referrals made on or after January 1, 1992, and other provisions apply to referrals made on or after December 31, 1994.

(e) Civil money penalty and exclusion for circumvention.—Physicians and entities are precluded from entering into cross-referral arrangements which the physician or entity knows or should know has a principal purpose of inducing referrals to another entity.

(f) Definition of direct supervision.—No provision.

Explanation of Provision.—(a) Financial relationship.—The definition of financial relationship would be clarified to provide that an interest held indirectly (such as in a trust that holds an investment or ownership interest) is a financial relationship.

(b) Payment by a physician.—The exception for payments by a physician for items and services would be modified to require that the items and services be furnished at a price that is consistent with fair market value.

(c) Reporting requirements.—Reporting requirements would be expanded to require physicians to report investment and compensation arrangements in addition to ownership information.

(d) Effective dates.—The application of effective dates with respect to exceptions in current law would be clarified.

(e) Civil money penalty and exclusion for circumvention.—The language for the sanction authority for circumvention schemes would be clarified.

(f) Definition of direct supervision.—Directly supervised would mean that the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the person (whether or not an employee of the physician or group practice) is performing the services.

Effective Date.—Subsections (a), (b) and (e), (f) would be effective January 1, 1996. Subsections (c), and (d) would be effective as if included in OBRA '93.

Title X. Long-Term Care

Subtitle A. Long-term care program

Sec. 1. Establishment of Long-Term Care Program for Home and Community-Based Services

Present Law.—There is no single Federal program that provides systematic support for long-term care. Medicare provides limited coverage for nursing home and home health care for persons who require skilled medical care. Medicaid, the Federal-State health program for the poor, covers nursing home care and limited amounts of home and community-based care. It does so, however, only for persons who are poor by welfare program standards or for those who have become poor as the result of depleting assets and income on the cost of their care. Three other Federal programs—the Social Services Block Grant, the Supplemental Security Income program, and the Older Americans Act program—provide limited support for community-based long-term care for disabled persons.

Explanation of Provision.—The Secretary would establish a new long-term care program under Title 24 of the Social Security Act to provide home and community-based services for individuals with severe disabilities, without regard to age or income through approved State plans.

Effective Date.—Effective for items and services provided on or after October 1, 1999.

Sec. 2. Individuals with Severe Disabilities Defined

Present Law.—No provision.

Explanation of Provision.—Severely disabled persons of all ages and income could be eligible for benefits under the new program. Four categories of disabled persons would be eligible for services, provided they require assistance for at least 100 days: individuals who require hands-on or standby assistance, supervision or cueing to perform three of five activities of daily living (ADLs) defined as bathing, dressing, toileting, transferring, and eating; individuals with severe or profound mental retardation, as determined according to a protocol specified by the Secretary; and severely disabled children under six years of age, who have a severe disability or chronic condition.

The determination of eligibility would be made by individuals or entities designated under the State plan. To determine eligibility, such individuals or entities would use a uniform protocol, consisting of an initial screening and assessment specified by the Secretary.

The plan would specify the process for an initial screening of individuals who appear to have some reasonable likelihood of meeting the criteria for eligibility. The determination that an individual meets the eligibility criteria would be considered effective under the State plan for a period of not more than 12 months. A reassessment would be made if there is a significant change in the individual's condition that may effect such determination. The State plan would specify a fair hearing process that would be made available to individuals for appeals of any determinations.

Effective Date.—Effective for items and services provided on or after October 1, 1999.

Sec. 3. Home and Community-Based Services Defined

Present Law.—No provision.

Explanation of Provision.—Individuals provided services under the new program could receive the following home and community-based long-term care items and services: agency-administered and consumer-directed personal assistance services, case management, homemaker and chore assistance, home modifications, respite services, assistive devices, adult day services, habilitation and rehabilitation, supported employment, home health services and any other care or assistive services approved by the Secretary that are determined by State agency to help individuals with severe disabilities remain in their homes or communities. Vouchers or cash payments could also be provided for use by eligible individuals for covered services. Providers of home and community-based services would not be prohibited from providing case management services, if such an arrangement is consistent with the provisions of an approved State plan.

Services that would be excluded from coverage under the long-term care program would include: room and board, services furnished in a hospital, nursing facility, intermediate care facility or other institutional setting specified by the Secretary, or any items or services otherwise covered under Medicare Parts A, B or C.

Cost-sharing would be imposed for covered services, in the form of coinsurance, based upon the amount paid under the new program for such service. No coinsurance, other than nominal cost-sharing, would be imposed on individuals with income less than

150 percent of the Federal poverty level. The coinsurance rate would be based upon income, and set at: 10 percent for individuals with income between 150 and 200 percent of the Federal poverty level; 20 percent for individuals with income between 200 and 250 percent of the Federal poverty level; and 25 percent for individuals with income equal to or exceeding 250 percent of the Federal poverty level. Each State, or an agency designated by the State, would determine the income of an individual with disabilities for purposes of determining coinsurance amounts, in a manner specified by the Secretary.

Each State would specify in its plan the following, with respect to covered services: (1) the methods and standards used to select the types, and the amount, duration and scope of home and community-based services available under the plan for each of the four categories of severely disabled individuals; (2) how the services provided meet the needs of individuals within each of the four categories; (3) the extent and manner in which such services would be allocated among the four categories of severely disabled individuals; (4) the manner in which services would be coordinated with each other and other health and long-term care services available outside the plan for individuals with severe disabilities, and (5) the manner in which individuals with severe disabilities would be assisted in obtaining services from other programs for which they may qualify, including home health services covered under Medicare Parts A, B, and C, and home and community-based services under the State Medicaid plan.

The services provided under the plan would be furnished in a manner that permits sufficient flexibility for providers to meet the needs of eligible individuals in a cost-effective manner, and that takes into account the availability of informal care.

Effective Date.—Effective for items and services provided on or after October 1, 1999.

Sec. 4. Administration Through State Plans

Present Law.—(a) General requirement.—No provision.

(b) Plan requirements.—No provision.

(c) Standards for plan approval.—No provision.

(d) Monitoring state performance.—No provision.

(e) Requirements relating to payment for services.—No provision.

(f) Quality and safeguards.—No provision.

Explanation of Provision.—(a) General requirement.—Any State would be required to have a plan approved by the Secretary for providing home and community-based services to individuals with severe disabilities, as a condition of receiving payments of Federal funds under this program. The Secretary would not be permitted to approve a plan unless the Secretary determines that the plan meets the requirements specified in this section.

(b) Plan requirements.—

(i) Eligibility process.—Each plan would be required to specify the process to determine if individuals meet the defined eligibility criteria.

(ii) Specification of services, cost-sharing, types of providers and requirements for participation.—Each plan would be required to specify the home and community-based services to be provided to

individuals determined to meet the eligibility criteria. Each plan would be required to impose the specified cost-sharing schedule with respect to covered services, and would be required to specify the types of providers eligible to participate in the program under the plan, and any requirements for participation applicable to each type of provider.

(iii) Provision of services.—The plan would require that home and community-based services be provided according to an individualized plan of care, which would be based upon an assessment of the individual's need for services. The plan of care would be developed in consultation with the individual and the individual's family, and would be periodically reviewed and updated.

(iv) Payments for services.—The plan would specify that payments for services would be provided in a manner consistent with schedules and payment methodologies defined in subsection (e) below.

(v) Budgeting and fiscal management.—Each State plan would provide assurances that not more than an amount or level of expenditures, specified by the Secretary, would be used for administrative purposes. The plan would also provide assurances that Federal funds would not be used to provide for the State share of expenditures required under this program. In addition, the plan would specify a method for establishing priorities, in the event that funds are insufficient to cover all eligible individuals with severe disabilities, and that it would give priority to individuals who are already being served under the program, before providing services to others.

(vi) Quality assurance and safeguards.—The plan would provide for quality assurance and safeguards for applicants and beneficiaries, consistent with the requirements of subsection (f).

(vii) General administration.—Each State plan would be required to designate a State agency or agencies to manage and coordinate benefits under the plan, in accordance with the specifications included in the plan. A State would be permitted to contract with or establish local care coordination agencies throughout the State to assure the availability of home and community-based services to individuals with severe disabilities residing throughout the State. Each plan would be required to specify how the plan would be integrated with other programs that provide home and community-based services to individuals with severe disabilities, and how the plan would be coordinated with benefits covered under private qualified health plans, and benefits covered under Medicare Parts A, B and C.

(viii) Reports to the secretary and audits.—The plan would provide that the State will furnish to the Secretary such reports as the Secretary determines are necessary to monitor the State's administration of its plan, and that the State would cooperate with audits determined by the Secretary to be necessary to assure compliance with the State plan.

(c) Standards for plan approval.—The Secretary would establish standards for approval of State plans, and may establish a deadline for the submission of a plan before the beginning of a fiscal year, as a condition of its approval for a given fiscal year.

(d) Monitoring State performance.—The Secretary would be required to monitor the performance of States in carrying out plans approved by the Secretary, and would evaluate the performance of State agencies in carrying out their programmatic and fiscal responsibilities. In evaluating the performance of States, the Secretary would take into account at least the following factors: the plan's ability to maximize the provision of services within the State's allocation; the State's success at finding alternative sources of funding to pay for services authorized under a plan of care; the plan's ability to maintain individuals with severe disabilities outside an institutional setting, and the State's ability to implement the requirement that the plan is a secondary payer to Medicaid, Medicare Parts A, B, and C, and other programs that provide home and community-based care.

(e) Requirements relating to payment for services.—Provider payments would be subject to fee schedules or prospective payment methodologies established by the Secretary. These amounts would be adjusted for variations in area wage levels and other factors deemed appropriate by the Secretary. In their absence, States would be permitted to make payments to providers on behalf of eligible individuals that are reasonable to ensure adequate participation and access to covered services. Extra billing would be prohibited.

The State plan may provide for the use of vouchers and cash payments directly to individuals with severe disabilities, and would specify the methods and criteria used to set rates for such cash payments and vouchers. With respect to such consumer-directed services, the agency designated by the State to administer the home and community-based program could provide an entity, other than the consumer or the individual provider, which would (i) inform recipients and providers of rights and responsibilities under all Federal and other applicable labor and tax laws, and (ii) would act as the employer of the home care provider for the purpose of assuming responsibility for effective billing, payments for service tax withholding, unemployment and workers. Service recipients, would retain the right to select, hire, terminate and direct the work of a home care provider.

(f) Quality and safeguards.—In order to assure the health and safety of individuals with severe disabilities, the Secretary would establish by not later than July 1, 1999, quality assurance and certification requirement for providers to receive payments under the plan, and for the enforcement of any such requirements under the plan. The State plan would also provide safeguards in order to restrict the use or disclosure of information concerning applicants and beneficiaries served under the plan. The State plan would also provide safeguards against physical, emotional or financial abuse or exploitation of individuals served under the State program.

Effective Date.—Effective for items and services provided on or after October 1, 1999.

Sec. 5. Payments to States and Medicaid Maintenance of Effort

Present Law.—(a) Payments to States.—No provision.

(b) Medicaid maintenance of effort.—No provision.

Explanation of Provision.—(a) **Payments to States.**—The Secretary would authorize payments to each State with an approved plan for each fiscal year for the purpose of providing home and community-based services under the new long-term care program.

A base Federal allotment equal to 20 percent of the State allocation would be made to any State with a plan approved by the Secretary, without regard to State contributions, provided the funds are spent pursuant to an approved State plan. State contributions toward the new long-term care program would not be required; however, Federal funds provided to the State would be increased for any State that elects to contribute up to twenty percent of the estimated total program allocation for use in the State.

The allocation of Federal funds to a given State would depend upon the amount of voluntary contributions made by the State. A State that makes a contribution of less than ten percent of the estimated total State program allocation would be entitled to receive a base allotment of twenty percent of the full Federal allocation. In addition to the base allotment, Federal payments to States would increase, on a sliding-scale basis, based upon the level of voluntary State contributions provided. A State that contributes the maximum contribution of twenty percent would be entitled to receive the full eighty percent Federal allocation.

The Secretary would allocate the total national long-term care allocation amount for each fiscal year among States. For any fiscal year, the national long-term care allocation amount would be 125 percent of the Federal funds available in a given year, or an amount equivalent to the sum of total Federal funds and State funds, assuming full participation by all States. The Secretary would allocate the amount in accordance with a formula based on: (i) the number of severely disabled persons within each of the four categories of eligible individuals in that State; and (ii) the average per capita spending amounts within each State within each of the eligibility categories for home and community-based services.

In the event that all States do not participate fully in the new program, the residual Federal funds that would have been available to such States would be redistributed consistent with the formula, to the fully participating States, with no additional State contribution required.

(b) **Medicaid maintenance of effort.**—To ensure that new Federal dollars do not substitute for Medicaid spending, and that the new long-term care program provides services to individuals not otherwise covered under the Medicaid program, States would be required to maintain at least their current level of effort for home and community-based services, indexed between 1994 and 1998 to the nominal growth in per capita gross domestic product, indexed in subsequent years to the rate of growth in Medicare spending, as specified in Title VIII of this Act.

The Secretary would be authorized to withhold amounts available to the State under the new long-term care program if the State fails to maintain the required level of effort under the Medicaid program.

The Secretary would be required to reduce the amount of payments otherwise made to a State to provide services under the program by the amount of any expenditures provided to individuals

otherwise entitled to benefits under the State Medicaid program or the Medicare program, including Part C.

Effective Date.—Effective for items and services provided on or after October 1, 1999.

Sec. 6. Federal Funding

Present Law.—No provision.

Explanation of Provision.—Budget authority would be provided in advance of appropriations acts, and would represent an obligation of the Federal government to provide for the payment of amounts for all State plans: \$3.0 billion in fiscal year fiscal 2000; \$4.0 billion in fiscal 2001; \$6.0 billion in fiscal 2002; \$8.0 billion in fiscal 2003; and \$10 billion in fiscal 2004.

In subsequent years, the obligation of the Federal government would be indexed to the allowable rate of growth in Medicare Part C as described in Title VIII.

Effective Date.—Effective for items and services provided on or after October 1, 1999.

Subtitle B. Federal standards for private long-term care insurance policies

Sec. 7. Establishment and Enforcement of Standards

Present Law.—In general, Federal standards have not been established for health plans sold to individuals and employers. Federal standards under section 1882 of the Social Security Act apply to Medicare supplemental insurance policies.

Standards for Medicare supplemental insurance policies have been developed by the National Association of Insurance Commissioners (NAIC), subject to approval by the Secretary. States, subject to approval by the Secretary, may enforce the Federal standards by adopting a regulatory program approved by the Secretary as meeting the Federal requirements. In the case of a State that does not have an approved regulatory program, the Secretary enforces standards for Medicare supplemental insurance policies.

Explanation of Provision.—The Secretary of HHS would promulgate regulations by July 1, 1995, to implement Federal standards for private long-term care insurance policies sold to individuals and employers. The Secretary would consult with the NAIC on standards for Federal long-term care insurance policies.

States would enforce the standards for all long-term care insurance policies. The Secretary would certify State compliance and would assume responsibility for enforcing the standards in a State that did not comply.

No individual or entity would be permitted to market a private long-term care insurance policy that fails to meet the requirements of this Title. If a policy is found to be out of compliance with the provisions, a fine would be levied up to \$10,000 per violation.

Effective Date.—In general, States would be required to adopt the Federal standards effective for private long-term care insurance policies beginning on January 1, 1997. Any State in which the legislature was not scheduled to meet during the year prior to the date by which the State must adopt the Federal standards would

be required to adopt the standards by the first quarter after the close of the next scheduled meeting of the State legislature, or on January 1, 1998, whichever is earlier.

Penalties for non-compliance would be effective for long-term care insurance policies sold or issued in a State on or after the date on which the Federal standards take effect in a State.

Sec. 8. Federal Standards and Requirements

Present Law.—Federal standards have not been established for private long-term care insurance policies sold to individuals and employers. The NAIC has developed the Long-Term Care Insurance Model Act and Model Regulation for regulating long-term care insurance. The States regulate long-term care insurance products. Generally, the State laws and regulations are based, at least in part, on the NAIC standards.

(a) Requirements to facilitate understanding and comparison of benefits.—No provision.

(b) Inflation protection.—No provision.

(c) Non-forfeiture benefits.—No provision.

(d) Requirements relating to sales practices.—No provision.

(e) Continuation, renewal, replacement, conversion and cancellation rules.—No provision.

(f) Payment of benefits.—No provision.

(g) Relation to State law.—No provision.

Explanation of Provision.—(a) Requirements to facilitate understanding and comparison of benefits.—The Secretary, in consultation with the NAIC, would develop and propose standardized formats and terminology that would be used in all long-term care insurance policies. The Secretary would establish other requirements to promote consumer understanding and to facilitate comparison of benefits.

Insurers would be required to use uniform terminology, uniform terms and uniform formats, in accordance with regulations promulgated by the Secretary.

A standard outline of coverage would be required for all long-term care insurance policies. It would include a readily understood statement, in boldface type, on the face of the document, explaining that the outline is a summary, rather than the contract of insurance. Insurers would be required to develop an outline of coverage, in a uniform format, for each long-term care insurance policy, and would be required to make the outline of coverage available to each potential purchaser, each insured individual and each potential purchaser. The outline would reflect the contents of the policy clearly and accurately, and would be updated periodically, in a manner specified by the Secretary, in consultation with the NAIC.

The outline of coverage would include a full description of benefits, including services that would be provided for insured individuals living in residential care facilities, the terms for obtaining upgraded benefits, the “triggers” for benefits, and the principal exclusions from and limitations on coverage. The outline of coverage would include a statement of the terms under which a policy may be returned (with premium refunded) during a period for an initial examination of the policy, continued in force or renewed, or converted from group to an individual policy. The outline would in-

clude a statement of the circumstances under which a policy may be terminated, and if applicable, the circumstances under which non-forfeiture benefits could be obtained.

The outline of coverage would include a statement of the total annual premium, any expected premium increases or limitations in annual premium increases associated with automatic or optional benefit increases, including inflation protection, and any circumstances under which the payment of the premium would be waived.

The outline would include information on national average costs, and the variations in such costs, for nursing facility care and other covered benefits, and a statement that this national average varies by geographic region. The Secretary would be required to publish, on an annual basis, the national average costs of nursing facility care, home health care services and other long-term care services as may be deemed appropriate by the Secretary. The outline of coverage would include a comparison of benefits over a period of 20 years for policies with and without inflation protection, and would be required to state whether the amount of benefits would increase over time, and any limitations on any premium increases for such benefit increases.

Each insurer would be required to report, at least annually, to the State Insurance Commissioner in any State in which a policy is sold or issued, in a manner specified by the Secretary. Information to be reported would include: the standard outline of coverage; lapse rates and replacement rates; the ratio of premiums collected to benefits; reserves; and written materials used in the sale or promotion of policies.

The Secretary, in consultation with the NAIC, would issue regulations for the terms of and benefits under long-term care insurance policies. A long-term care insurance policy would not be permitted to condition eligibility for benefits: (i) on the need for another type of service (such as prior hospitalization), or a higher level of care; (ii) on any particular medical diagnosis, including any acute condition, or on one of the group of diagnoses; (iii) on services furnished by licensed or certified providers, and on compliance by such providers with conditions not required by Federal or State law; or (iv) on the provision of such services by a provider, or in a setting, providing a higher level of care than that required by an insured individual.

A long-term care insurance policy that provides benefits for home and community-based services provided in a setting other than a residential care facility would not be permitted to limit benefits to services provided by registered nurses or licensed practical nurses, nor limit benefits to services provided by entities participating in Medicare and Medicaid. Such a policy would be required to provide, at a minimum, benefits for personal assistance with activities of daily living, home health care, adult day care and respite care.

A long-term care insurance policy that provides benefits for services in nursing facilities would be required to provide benefits for services provided by all types of nursing facilities licensed by the State, and could provide benefits for care in other residential facilities.

Long-term care insurance policies would not be permitted to discriminate with respect to eligibility for benefits or amount of benefits under the policy in the treatment of: Alzheimer's disease or other progressive degenerative dementia, any organic or inorganic mental illness, mental retardation or any other cognitive or mental impairment, or HIV infection or AIDS.

(b) Inflation protection.—An insurer would be required to offer the purchaser the option to obtain coverage under the policy for annual increases in benefits. The benefits under a policy would increase by not less than five percent per year compounded. Inflation protection would be excluded from the coverage only if the insured individual rejected in writing the option to obtain such coverage.

(c) Non-forfeiture benefits.—All long-term care insurance policies would be required to include defined non-forfeiture benefits, as specified by the Secretary. The Secretary, in consultation with the NAIC, would be required to promulgate regulations for an appropriate non-forfeiture benefit for policies that lapse, including policies that lapse for nonpayment of premiums and non-renewal, but excluding policies that lapse for reason of death. Such benefits could include: shortened benefit periods where a policy remains in effect for an abbreviated period of time after the policy lapses, or reduced paid-up benefits where the indemnity level is reduced by a specified amount. The non-forfeiture benefit would increase proportionately to the amount of premiums paid by the insured individual.

(d) Requirements relating to sales practices.—Any insurer offering a long-term care insurance policy would be required to meet such requirements pertaining to the content, format and use of application forms. Any insurer that sold or offered a policy could not offer such a policy through an agent who failed to comply with the minimum standards with respect to training and certification established by the Secretary.

The following practices would be prohibited in the sale or offering of long-term care insurance policies: (i) false and misleading representation; (ii) inaccurate completion of medical history by insurer; (iii) using force, fright or undue pressure to induce the purchase of a policy; and (iv) cold lead advertising, which means any method of inducing an individual to contact an insurer or agent for the purpose of inducing the individual to buy insurance, if that purpose is not disclosed conspicuously.

An insurer or agent would be prohibited from selling a policy that the insurer or agent knows (or should know) duplicates coverage that the purchaser already has, except if the policy is intended to replace the other policy, or if the benefits under the new policy are fully payable directly to or on behalf of the individual without regard to other long-term care coverage of the individual.

(e) Continuation, renewal, replacement, conversion and cancellation of policies.—Each insured individual would have an unconditional right to return a policy within 30 days after the date of its issuance, and would be able to obtain a full refund of the premium paid.

In general, insurers would not be permitted to cancel, or refuse to renew any long-term care insurance policy for any reason other

than for fraud, material misrepresentation, or for non-payment of premium.

Each policy would contain a provision that states the duration of the policy, the right of the insured individual to renewal, the date by which the option to renew must be exercised, and applicable restrictions.

Continuation and conversion rights would be established with respect to group policies. Individuals would be permitted to continue or convert policies. A group policy would meet the conversion requirements if entitled individuals covered under the group policy are issued a replacement policy providing benefits substantially equivalent to the benefits, or greater than the benefits, without requiring evidence of insurability, and at premium rates no higher than would apply if the individual had obtained it under a replacement policy.

Any insurer would have the right to cancel a policy, or to refuse to pay a claim, based on evidence that the insured made false representations or knowingly failed to disclose information on the application. Insurers would have the right to cancel policies for non-payment of premiums, subject to non-forfeiture requirements.

Insurers would be required to reinstate full coverage of an individual who canceled due to non-payment of premiums, retroactive to the effective date of cancellation, if the insurer receives evidence from a representative of the individual that the individual was incapacitated, and receives payment of all premiums due and past due and charges for late payment.

At the time of sale, the issuer would be required to offer the insured individual the right to designate a representative to communicate with the insurer regarding premium payments, in the event of nonpayment of premiums, or the right to sign a statement declining to designate a representative.

(f) Payment of benefits.—The Secretary would promulgate regulations establishing requirements with respect to claims for and payment of benefits under a policy. Each policy would specify the threshold for “triggering” eligibility for benefits, including levels of functional or cognitive status. The policy would provide for a procedure to determine whether threshold conditions, based upon uniform assessment standards, procedures and formats, were met.

Insurers would be required to provide an explanation in writing of the reasons for a denial of a claim or for partial payment of a claim. Insurers would be required to provide a policyholder with a written explanation of grievance procedures available to the policyholder. Insurers would be required to provide an administrative procedure under which an individual would be able to seek reconsideration of any denial of a claim, or partial payment of a claim.

In the event of a disagreement or of inconsistencies, the individual policyholder would be permitted to appeal an insurer’s decision to the complaint review office established by the State (as described in Title IX of this Act). The complaint review office would be required to utilize appropriately trained individuals in cases involving long-term care insurance disputes. Any decision made by a state review office would be non-binding, and nothing would prohibit an individual from seeking review through the judicial system.

(g) Relation to State law.—Uniform Federal standards and provisions provided under this Act would pre-empt State laws with respect to standards for private long-term care insurance.

Effective Date.—The Federal standards would be effective for long-term care insurance policies sold or issued in a State on or after the date on which the Federal standards take effect in a State.

Title XI. Revenue Provisions

Subtitle A. Increase in excise taxes on tobacco products

Present Law.—(a) Tax rates.—Excise taxes are imposed on the manufacture or importation of cigarettes, cigarette papers and tubes, snuff, chewing tobacco, and pipe tobacco. The present-law tax rates are as follows:

Cigarettes.—Small cigarettes (weighing no more than 3 pounds per thousand).¹—\$12 per thousand (i.e., 24 cents per pack of 20 cigarettes).

Large cigarettes (weighing more than 3 pounds per thousand).²—\$25.20 per thousand.

Cigars.—

Small cigars (weighing no more than 3 pounds per thousand).—\$1.125 per thousand.

Large cigars (weighing more than 3 pounds per thousand).—12.75 percent of manufacturer's price (but not more than \$30 per thousand).

Cigarette Papers and Tubes.—

Cigarette papers.³—0.75 cent per 50 papers.

Cigarette tubes.⁴—1.5 cents per 50 tubes.

Snuff, Chewing Tobacco, Pipe Tobacco.—

Snuff.—36 cents per pound.

Chewing tobacco.—12 cents per pound.

Pipe tobacco.—67.5 cents per pound.

(b) Exemptions; use of revenues.—No tax is imposed on tobacco products exported from the United States. Exemptions also are allowed for (1) tobacco products furnished by manufacturers for employee use or experimental purposes; and (2) tobacco products to be used by the United States. In addition, no tax is imposed on tobacco to be used in "roll-your-own" cigarettes.

Revenues from the tobacco products excise taxes are retained in the general fund of the Treasury. Revenues from taxes on tobacco products brought into the United States from Puerto Rico are transferred ("covered over") to Puerto Rico if the products satisfy a domestic content requirement.⁵ No Federal excise tax is imposed on tobacco products sold in Puerto Rico.

¹ Most taxable cigarettes are classified as small cigarettes.

² Large cigarettes measuring more than 6½ inches in length are taxed at the rate prescribed for small cigarettes, counting each 2¾ inches (or fraction thereof) as one cigarette.

³ Cigarette papers measuring more than 6½ inches in length are taxed at the rate prescribed, counting each 2¾ inches (or fraction thereof) as one cigarette paper. No tax is imposed on a book or set of cigarette papers containing 25 or fewer papers.

⁴ Cigarette tubes measuring more than 6½ inches in length are taxed at the rate prescribed, counting each 2¾ inches (or fraction thereof) as one cigarette tube.

⁵ Code section 7652(d) provides that an article, other than an article containing distilled spirits, shall not be treated as produced in Puerto Rico unless the sum of (a) the cost or value of

Explanation of Provision.—(a) Tax rates.—The bill would increase the excise tax rate on small cigarettes by \$22.50 per thousand (45 cents per pack of 20 cigarettes) and on large cigarettes by \$47.25 per thousand. The tax on other currently taxable tobacco products would be increased by approximately 187.5 percent and a \$1.94 per pound tax would be imposed on “roll-your-own” tobacco.

Each of these rate increases would be phased-in over five years, in the following approximate percentages: August 1, 1995, 34 percent; January 1, 1997, 56 percent; January 1, 1998, 78 percent, and January 1, 1999, 100 percent. This phase-in would produce the following per pack of 20 small cigarettes rate increases: August 1, 1995, 15 cents; January 1, 1997, 25 cents; January 1, 1998, 35 cents; and January 1, 1999, 45 cents.

When fully phased-in beginning in 1999, the new tax rates on all tobacco products would be:

Cigarettes.—

Small cigarettes (weighing no more than 3 pounds per thousand).—\$34.50 per thousand (i.e., 69 cents per pack of 20 cigarettes).

Large cigarettes (weighing more than 3 pounds per thousand).—\$72.45 per thousand.

Cigars.—

Small cigars (weighing no more than 3 pounds per thousand).—\$3.23 per thousand.

Large cigars (weighing more than 3 pounds per thousand).—37 percent of manufacturer’s price (but not more than \$86.25 per thousand).

Cigarette Papers and Tubes.—

Cigarette papers.—2.16 cents per 50 papers.

Cigarette tubes.—4.31 cents per 50 tubes.

Snuff, Chewing Tobacco, Pipe Tobacco, “Roll-Your-Own” Tobacco.—

Snuff.—\$1.035 per pound.

Chewing tobacco.—\$0.35 per pound.

Pipe tobacco.—\$1.94 per pound.

“Roll-your-own” tobacco.—\$1.94 per pound.

(b) Exemptions; use of revenues.—The bill also would repeal the present-law exemptions for tobacco products provided to employees of the manufacturer and for use by the United States, and would include the following administrative and compliance provisions:

(i) The exemption for exports would be limited to products that are marked or labeled under Treasury Department rules designed to prevent the diversion of such products into the domestic market;

(ii) Re-importation of tobacco products previously exported without payment of tax (other than for return to the manufacturer) would be prohibited and a new penalty, equal to the greater of \$1,000 or five times the amount of tax, would be imposed on all parties involved in any prohibited re-importation (All tobacco products and cigarette papers and tubes, as well as all vessels, vehicles, and aircraft used in such re-importations, would be subject to seizure by the United States.);

the materials produced in Puerto Rico plus (b) the direct costs of process operations performed in Puerto Rico equals or exceeds 50 percent of the value of the article as of the time it is brought into the United States.

(iii) The current manufacturer inventory maintenance and reporting requirements, criminal penalties, and forfeiture rules would be extended to importers of tobacco products;

(iv) The present-law exemption for books or sets of cigarette papers containing 25 or fewer papers would be repealed; and

(v) Cover over of tobacco product revenues to Puerto Rico and the Virgin Islands would be limited to present-law tax levels.

In addition, the bill would apply the increases in the Federal excise tax rates on tobacco products (e.g., 45 cents per pack of small cigarettes) to tobacco products manufactured and sold in Puerto Rico. Revenues derived from the increased excise tax rates would not be covered over to Puerto Rico. The tax would be collected in the same manner as the tax currently is collected on tobacco products manufactured and sold in the mainland United States.

Effective Date.—The provision generally is effective for tobacco products removed after July 31, 1995. A floor stocks tax is imposed on taxable tobacco products held on the effective date and on each subsequent rate increase date.

Subtitle B. Treatment of employer-provided health care

Sec. 1. Cafeteria Plans and Flexible Spending Arrangements

Present Law.—Health benefits May Not Be Provided Under Cafeteria Plans or Flexible Spending Arrangements Other Than Medical Savings Accounts (sec. 11201 of the bill, secs. 106(b), 125, 3121(a), 3231(e), 3306(b), and 3401(a) of the Code, and sec. 209(a) of the Social Security Act).

(a) Cafeteria plans.—Under present law, compensation generally is includible in gross income when actually or constructively received, i.e., when it is made available to the individual or the individual has an election to receive such amount. Under one exception to the general principle of constructive receipt, no amount is included in the gross income of a participant in a cafeteria plan maintained by an employer solely because the participant may elect among cash and certain employer-provided qualified benefits. In general, a qualified benefit is a benefit that is excludable from an employee's gross income by reason of a specific provision of the Internal Revenue Code. Employer-provided accident or health coverage is a qualified benefit.

The cafeteria plan exception from the principle of constructive receipt also applies for employment tax purposes.

(b) Flexible spending arrangements.—A flexible spending arrangement ("FSA") is a reimbursement account or similar arrangement under which an employee is reimbursed for medical expenses or other employer-provided qualified benefits, such as dependent care. FSAs that are part of a cafeteria plan generally are funded through salary reduction. FSAs may also be provided by an employer outside a cafeteria plan. FSAs are commonly used, for example, to reimburse employees for medical expenses not covered by insurance. If certain conditions are satisfied, amounts reimbursed under an FSA are excludable from gross income and wages for income and employment tax purposes.

Under present law, there is no special exclusion from income for benefits provided under an FSA. Thus, benefits provided under an

FSA are excludable from income only if there is a specific exclusion otherwise applicable to the benefits (e.g., the exclusion under sec. 106 for accident and health benefits). FSAs that are part of a cafeteria plan must comply with the rules generally applicable to cafeteria plans. One such rule is that a cafeteria plan may not offer deferred compensation, except through a qualified cash or deferred arrangement (sec. 401(k)). According to proposed Treasury regulations, a cafeteria plan permits the deferral of compensation if it includes a health FSA that reimburses participants for medical expenses incurred beyond the end of the plan year. Thus, in the case of an FSA that reimburses employees for out-of-pocket medical expenses, amounts in an employee's account that are not used for medical expenses incurred before the end of a plan year must be forfeited. This rule is often referred to as the "use it or lose it" rule.

The proposed regulations define a health FSA as a benefit program that provides employees with coverage under which specified, incurred expenses may be reimbursed (subject to reimbursement maximums and any other reasonable conditions) and under which the maximum amount of reimbursement that is reasonably available to a participant for a period of coverage is not substantially in excess of the total premium (including both employee-paid and employer-paid portions of the premium) for such participant's coverage. A maximum amount of reimbursement is not substantially in excess of the total premium if the maximum amount is less than 500 percent of the premium.

Explanation of Provision.—(a) Cafeteria plans.—Under the bill, accident or health coverage provided through a cafeteria plan and accident or health benefits provided under an FSA would not be excludable from income and wages for income and employment tax purposes.⁶

(b) Flexible spending arrangements.—The bill would define a flexible spending arrangement in the same manner as the proposed regulations under present law. Thus, under the bill, a flexible spending arrangement would include a benefit program that provides employees with coverage under which specified incurred expenses may be reimbursed (subject to reimbursement maximums and other reasonable conditions) and the maximum amount of reimbursement that is reasonably available to a participant for the coverage is less than 500 percent of the cost of such coverage. Under the bill, in the case of an insured plan, the maximum amount reimbursed would be determined on the basis of the underlying coverage.

Effective Date.—The provision would be generally effective on and after January 1, 1995. Two transition rules would apply with respect to certain plans. First, in the case of an employee covered by a cafeteria plan or FSA established pursuant to a collective bargaining agreement ratified before June 30, 1994, the repeal of the

⁶The bill would not otherwise limit or modify the present-law exclusion for employer-provided health benefits. Thus, the Committee does not intend to change the tax treatment of certain employer-provided health promotion activities that are provided on the worksite. For example, such activities could include blood pressure screening and counseling, weight loss clinic, cholesterol screening, exercise promotion, smoking cessation, primary care services, drug testing, Federally mandated physical exams (DOT, NRC), and mammography/prostate screening. To the extent these activities are currently excludable health benefits they would continue to be excludable under the bill.

exclusion for benefits provided under a cafeteria plan or FSA would not apply before the effective date of any amendment, modification, extension, or expiration of such bargaining agreement (without regard to any extensions ratified after June 30, 1994). This transition rule would also apply in the case of State and local government employees who are covered under a cafeteria plan or FSA established pursuant to a collective bargaining agreement.

Second, in the case of an employee of a State, county, or municipal government who is covered by a collective bargaining agreement ratified before June 30, 1994, and who is eligible to make contributions to a cafeteria plan or FSA established by State or local law which is in effect on June 30, 1994, the repeal of the exclusion for benefits provided under a cafeteria plan or FSA would not apply before January 1, 1999.

Sec. 2. Health Benefits Provided Under High Deductible Medical Savings Account Plans

Present Law.—Medical savings accounts are not currently afforded tax-favored status under the Code. However, present law contains provisions that provide taxpayers with some ability to pay for unreimbursed medical expenses on a tax-favored basis, including provisions relating to flexible spending arrangements (FSAs) and individual retirement arrangements (IRAs).

An FSA is a reimbursement account or similar arrangement under which an employee can be reimbursed for health care expenses not covered by insurance. If certain conditions are satisfied, amounts reimbursed under an FSA are excludable from gross income and wages for employment tax purposes. Amounts remaining in an FSA at the end of the year must be forfeited; they cannot be used for expenses in a subsequent year.

Certain individuals can make deductible contributions to an IRA of up to \$2,000 per year. An individual is generally not taxed on amounts held in an IRA, including earnings on contributions, until the amounts are withdrawn from the IRA. Amounts withdrawn from an IRA can be used for any purpose, including to pay medical expenses. Amounts withdrawn from IRAs are includible in income and generally are subject to an additional 10 percent excise tax if the withdrawal is made before age 59½. The 10-percent additional tax does not apply to distributions for medical costs that would be deductible medical expenses if the individual itemized deductions.

(a) Definition of High Deductible Plan.—No provision.

(b) Operation of Medical Savings Accounts.—No provision.

Explanation of Provision.—Under the bill, employers may offer eligible employees health coverage consisting of both (1) a high deductible plan and (2) a medical savings account. This combination would be referred to as a “high deductible medical savings plan”. Employers who are required to provide coverage under a private health plan would still be required to offer the guaranteed national benefit package to their employees.

Eligible employees include all employees other than employees who are reasonably expected to be eligible for subsidies under subtitle D of title XXIII of the Social Security Act or for a premium reduction.

The bill would not permit individuals that are not employees to have a high deductible medical savings plan. Such plans could be provided only by employers for their employees.

(a) Definition of high deductible plan.—Under the bill, high deductible plans would provide the same coverage as provided under the guaranteed national benefit package, except that such plans would have a higher deductible amount. High deductible plans would be subject to the same insurance reforms, as described in title V of the bill, as other plans of employers. The bill would not permit employers to self-insure high deductible health plans.

Under a high deductible plan, the deductible would be within the range of \$1,500 to \$2,500 for individual policies, and within the range of \$2,150 to \$3,750 for family policies. These ranges would be increased over time in the same manner, and in the same percentage amount, as the deductibles under the guaranteed national benefit package.

(b) Operation of medical savings accounts.—(i) Contributions to accounts.—If an employee elects a high deductible plan, the employer would be required to deposit in a medical savings account for the employee the difference between the employer contribution for the fee-for-service guaranteed national benefit package and the employer contribution for the high deductible plan. The bill would require the employer to pay the same percentage of the cost of the high deductible plan as it pays for the fee-for-service guaranteed national benefits package. Employees would be responsible for paying the difference between the actual premium and the amount of the premium contributed by the employer.

For example, if an employer pays the required 80 percent employer contribution for the fee-for-service guaranteed national benefit package, the employer would be required to pay 80 percent of the premium for the high deductible plan. The employer would deposit in a medical savings account the difference between 80 percent of the cost of the fee-for-service guaranteed national benefit package and 80 percent of the cost of the high deductible plan. However, if an employer pays 100 percent of the cost of the fee-for-service guaranteed national benefit package, the employer would be required to pay 100 percent of the premium for the high deductible plan. The employer would deposit in a medical savings account the difference between 100 percent of the cost of the fee-for-service guaranteed national benefit package and 100 percent of the cost of the high deductible plan.

Under the bill, employer contributions to the account would be excludable from gross income and wages for employment tax purposes.

(ii) Distributions from accounts.—Under the bill, distributions from medical savings accounts would be tax-free if used to pay medical expenses of the account beneficiary or his or her spouse or dependents. Medical expenses would include expenses that qualify as medical expenses under section 213 of the Code, other than the individual's share of health care insurance premiums.

Distributions not used for medical expenses would be includible in gross income and would be subject to an additional 100-percent tax when distributed. If an individual uses a distribution for nonmedical purposes and the individual has previously paid income

taxes on a portion of the distribution, then the amount includible in income and subject to the 100-percent penalty tax for the taxable year would be reduced by the amount previously included in income. Distributions after age 65 or after the individual dies or becomes disabled that are not used for medical purposes would be includible in gross income but the additional 100-percent tax would not apply.

Amounts distributed from a medical savings account could be rolled over tax-free to another medical savings account within 60 days of the date of the distribution.

(iii) *Taxation of accounts.*—The account beneficiary of a medical savings account would be treated as the owner of the account and would be taxed on the account in accordance with the rules applicable to grantor trusts. Thus, the bill would provide that earnings on amounts in the account be includible in the gross income of the account beneficiary annually. However, capital losses would not be allowed outside the account, so as to prevent a loss in the account from offsetting other unrelated income of the account beneficiary.

(iv) *Administration of accounts.*—A bank, insurance company, or other persons that meet requirements set forth by the Secretary of the Treasury could serve as the trustee of a medical savings account. The bill would require the trustee of the account to obtain such records as are necessary to determine whether a distribution is made for medical expenses. The bill also would require the trustee to report earnings to the account owner and the IRS. The Secretary of the Treasury could require such recordkeeping as he determines necessary, including information relating to deposits, withdrawals, and payments for medical expenses out of the account. Administrative rules similar to the rules applicable to IRAs would apply.

Effective Date.—The provision would be effective on and after January 1, 1998.

Sec. 3. Deduction for Health Insurance Costs of Self-Employed Individuals Increased and Made Permanent

Present Law.—Under present law, self-employed individuals cannot exclude the cost of health insurance from gross income. For this purpose, self-employed individuals include sole proprietors, partners in partnerships, and more than 2-percent shareholders of S corporations. Prior to January 1, 1994, a self-employed individual could deduct 25 percent of the health insurance costs of the individual and his or her spouse or dependents. The 25-percent deduction was not available for any month if the self-employed individual or his or her spouse were eligible for employer-paid health benefits. In addition, no deduction was available to the extent that the deduction exceeded the taxpayer's earned income.

Explanation of Provision.—The provision would extend the 25-percent deduction for health insurance expenses of self-employed individuals, effective for taxable years beginning after December 31, 1993. For taxable years beginning on or after January 1, 1998, the provision would permit self-employed individuals to deduct up to 80 percent of their health insurance expenses.

As under prior law, the 80-percent deduction would not be available to the extent that the deduction exceeds the taxpayer's earned income.

Under the provision, the 80-percent deduction would not be available for any month in which the self-employed individual or his or her spouse is (1) employed by an employer for at least 25 hours a week,⁷ or (2) eligible to participate in a subsidized private health plan maintained by an employer of the self-employed individual or his or her spouse. Limiting the deduction to 80 percent, rather than 100 percent, of the health insurance expenses of a self-employed individual would be intended to provide consistency between the tax treatment provided to employees with respect to employer-provided health care and the treatment of the health insurance expenses of self-employed individuals and to minimize the tax incentives for an individual to be classified as a self-employed individual. Because the bill would limit the required employer contribution to 80 percent of the premium with respect to an employee, some employers will not subsidize more than 80 percent of the cost of health insurance for their employees. Thus, if a self-employed individual were permitted to deduct 100 percent of his or her health insurance expenses, in some cases there would be an incentive to perform services as a self-employed individual, rather than as an employee.

Effective Date.—The 25-percent deduction would be extended effective for taxable years beginning after December 13, 1993, and before January 1, 1998. The 80-percent deduction would be effective for taxable years beginning on or after January 1, 1998.

4. *Limitation on prepayment of medical insurance premiums*

Present Law.—Under present law, a taxpayer who itemizes deductions may deduct amounts paid during the taxable year (if not reimbursed by insurance or otherwise) for medical care of the taxpayer, and the taxpayer's spouse and dependents to the extent that the total of such expenses exceeds 7.5 percent of the taxpayer's adjusted gross income (AGI).

Under a special rule, premiums paid during the taxable year by a taxpayer before he or she attains age 65 for insurance that covers medical care for the taxpayer after the taxpayer attains age 65, or the taxpayer's spouse or a dependent, are treated as expenses paid during the taxable year for insurance that constitutes medical care if premiums for the insurance are payable (on a level payment basis) under the contract for a period of 10 years or more or until the year in which the taxpayer attains age 65 (but in no case for a period of less than five years).

A series of revenue rulings has held that, under certain circumstances, the portion of a fee paid for lifetime care that is properly allocable to medical expenses is deductible in the year paid, even though the medical services will not be performed until a future time, if at all.⁸ The Internal Revenue Service has recently is-

⁷ In general, under the provision, an employer is not required to cover employees who work fewer than 25 hours per week under the employer's plan, although the employer is required to contribute to Medicare Part C on behalf of such employees.

⁸ See Rev. Rul. 75-302, 1975-2 C.B. 86; Rev. Rul. 75-303, 1975-2 C.B. 87; Rev. Rul. 76-481, 1976-2 C.B. 82.

sued a revenue ruling stating that the prior rulings should not be interpreted as allowing a current deduction of payments for future medical care (including medical insurance) extending substantially beyond the close of the taxable year in situations where the future care is not purchased in connection with obtaining lifetime care of the type described in the prior rulings.⁹ The recent revenue ruling states that it will not be applied to amounts paid before October 14, 1993, or to amounts paid on or after October 14, 1993, pursuant to the terms of a binding contract entered into before that date if such terms were in effect on that date.

Explanation of Provision.—The bill would provide that, for purposes of the itemized deduction for medical expenses, amounts paid during a taxable year that are allocable to insurance coverage or medical care to be provided more than 12 months after the month in which the payment is made are treated as paid ratably over the period during which the coverage or care is to be provided. The provision would not amend the special rule under present law for post-age 65 medical insurance.

Effective Date.—The provision would apply to amounts paid after December 31, 1994.

Subtitle C. Extending Medicare coverage of, and application of hospital insurance tax to, all state and local government employees

Present Law.—Under present law, State and local government employees hired before April 1, 1986, are not covered under Medicare unless a voluntary agreement is in effect. Although the hospital insurance payroll tax does not apply to such employees, they may receive Medicare benefits, for example, through their spouse. Medicare coverage and the hospital insurance payroll tax are mandatory for State and local government employees hired on or after April 1, 1986, and Federal employees.

For wages paid in 1994 to Medicare-covered employees, the total hospital insurance tax rate is 2.9 percent of total wages. One-half of the hospital insurance tax (1.45 percent) is imposed on the employee and one-half on the employer.

Explanation of Provision.—The provision would extend Medicare coverage on a mandatory basis to all employees of State and local governments not otherwise covered under present law, without regard to their dates of hire. These employees and their employers would be liable for the hospital insurance tax, and the employees would earn credit toward Medicare eligibility. Employee and employer liability for the hospital insurance tax would be phased in over a four-year period, with 25 percent of the applicable tax payable with respect to wages paid during 1997, 50 percent payable in 1998, 75 percent payable in 1999, and 100 percent payable in 2000.

In addition, service prior to January 1, 1997, of State and local government employees whose wages are subject to the hospital insurance tax solely because of the bill would be considered covered employment for purposes of determining eligibility for Medicare coverage. The Department of the Treasury would be required to reimburse the Federal Hospital Insurance Trust Fund for additional payments made, administrative expenses incurred, and any inter-

⁹ Rev. Rul. 93-72, 1993-94 IRB 7 (Nov. 1, 1993).

est losses which occur as a result of the recognition of the prior service of State and local government employees for Medicare eligibility purposes.

The provision would require that the Secretary of the Treasury, in consultation with State and local governments, provide procedures designed to ensure that individuals who perform Medicare-qualified government employment are informed of (1) their eligibility or potential eligibility for benefits under Medicare Part A, (2) the requirements for, and conditions of, eligibility for benefits under Medicare Part A, and (3) the necessity of filing a timely application as a condition of becoming entitled to benefits. These procedures would be required to give particular attention to individuals who apply for an annuity or retirement benefit based on a disability.

Effective Date.—The provision would apply to services performed by State and local government employees after December 31, 1996.

Subtitle D. Organizations providing health care services and related organizations

Sec. 5. Tax Treatment of Organizations Providing Health Care Services and Related Organizations

Present Law.—

Exempt status of charities

Code section 501(c)(3) lists certain types of organizations that are exempt from Federal income tax, including those organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes no part of the net earnings of which inures to the benefit of any private shareholder or individual. Contributions to such organizations generally are deductible for Federal income, estate, and gift tax purposes. In addition, such organizations are eligible for tax-exempt financing that is not subject to the State volume cap otherwise applicable to private users of tax-exempt financing and, in the case of hospitals, are exempt from the \$150 million limit otherwise applicable to the amount of tax-exempt financing from which a section 501(c)(3) organization can benefit.

Health care organizations as tax-exempt entities.—Although Code section 501(c)(3) does not specifically refer to furnishing medical care or operating a not-for-profit hospital, such activities have long been considered to further charitable purposes.¹⁰ However, the mere provision of not-for-profit medical care is not, by itself, sufficient to allow an organization to qualify for exemption under section 501(c)(3). Rather, an organization must demonstrate that its activities are targeted to a charitable class. The precise nature of that charitable class has been defined only through administrative guidance, and not by statute.

In 1956, the Internal Revenue Service (IRS) issued Revenue Ruling 56-185, 1956-1 C.B. 202, setting forth the conditions that a not-for-profit hospital must satisfy to qualify for recognition as a

¹⁰ Although not-for-profit hospitals generally are recognized as tax-exempt by virtue of being "charitable" organizations, some also may qualify for exemption as "educational" organizations because they are organized and operated primarily for medical education purposes.

tax-exempt charitable organization under section 501(c)(3). The IRS ruled that a hospital would be exempt if it met the following four conditions: (1) it must be organized as a not-for-profit organization for the purpose of operating a hospital for the care of the sick; (2) it must be operated, to the extent of its financial ability, for those not able to pay for the services rendered and not exclusively for those able and expected to pay;¹¹ (3) it must not restrict use of its facilities to a particular group of physicians; and (4) its earnings must not inure, directly or indirectly, to the benefit of any private shareholder or individual (this last requirement merely restated a restriction applicable to all organizations under section 501(c)(3)).

In 1969, the IRS issued Revenue Ruling 69-545, 1969-2 C.B. 117, which established the so-called "community benefit" standard. Relying upon regulations issued ten years earlier,¹² the IRS noted that the promotion of health is "one of the purposes in the general law of charity that is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community, such as indigent members of the community, provided that the class is not so small that its relief is not of benefit to the community." The IRS modified Revenue Ruling 56-185 to eliminate the specific requirement relating to caring for patients without charge or at rates below cost.

The "community benefit" standard, which remains the principal standard applied by the IRS today, focuses on a number of factors which indicate that the operation of a hospital benefits the community rather than serving private interests. In Revenue Ruling 69-545, the IRS determined that the community benefit standard was satisfied by a hospital that operated an emergency room open to all persons and provided hospital care in non-emergency situations for everyone able to pay the cost thereof, either themselves, or through third-party reimbursement.¹³ The hospital at issue in Rev. Rul. 69-545 also had a board of directors drawn from the community and an open medical staff policy, treated persons paying their bills with the aid of public programs (such as Medicare and Medicaid), and applied any surplus receipts to improving facilities, equipment, patient care, and medical training, education and research. The same "community benefit" standard applies in determining whether an

¹¹ With respect to the "financial ability" requirement, the IRS noted that: "The fact that its charity record is relatively low is not conclusive that a hospital is not operated for charitable purposes to the full extent of its financial ability. It may furnish services at reduced rates which are below cost, and thereby render charity in that manner. It may also set aside earnings which it uses for improvements and additions to hospital facilities. It must not, however, refuse to accept patients in need of hospital care who cannot pay for such services."

¹² Three years after publication of Revenue Ruling 56-185, the Treasury Department significantly revised its regulations interpreting section 501(c)(3). Treas. Reg. section 1.501(c)(3)-1(d)(2) provides that "the term 'charitable' is used in section 501(c)(3) in its generally accepted legal sense and is, therefore, not to be construed as limited by the separate enumeration in section 501(c)(3) of other tax-exempt purposes which may fall within the broad outlines of 'charity' as developed by judicial decisions."

¹³ In Rev. Rul. 83-157, 1983-2 C.B. 94, the IRS clarified that the operation of an emergency room was not a prerequisite for a hospital to have tax-exempt status under section 501(c)(3), if a State health planning agency made an independent determination that the operation of an emergency room would be unnecessary and duplicative. The IRS concluded that, in such a case, the presence of the other factors set forth Rev. Rul. 69-545 indicated that the hospital promoted the health of a class of persons broad enough to benefit the community.

HMO qualifies for tax-exempt status under section 501(c)(3), although slightly different characteristics are examined.¹⁴

Exempt status of social welfare organizations

Code section 501(c)(4) provides an exemption from income tax for non-profit organizations operated primarily to promote the common good and general welfare of the people in the community. Contributions to such organizations generally are not deductible for Federal income, estate, and gift tax purposes, and such organizations are not eligible to benefit from tax-exempt financing beyond financing available to other private users.

An HMO seeking exemption as a social welfare organization under section 501(c)(4) is not required to possess all of the same characteristics as an HMO that qualifies for exemption under section 501(c)(3); however, its activities generally must satisfy a community benefit standard similar to, but less exacting than, that imposed on a charitable HMO.¹⁵

Private inurement

Charities.—Section 501(c)(3) specifically conditions tax-exempt status for all organizations described in that section on the requirement that no part of the net earnings of the organization inures to the benefit of any private shareholder or individual (the so-called “private inurement test”).¹⁶

Social welfare organizations.—A tax-exempt social welfare organization described in section 501(c)(4) must be organized on a non-profit basis and must be operated exclusively for the promotion of social welfare. In contrast to section 501(c)(3), however, there is no specific statutory rule in section 501(c)(4) prohibiting the net earnings of a social welfare organization described in section 501(c)(4) from inuring to the benefit of a private shareholder or individual.¹⁷

Sanctions for private inurement and other violations of exemption standards

Organizations described in section 501(c)(3) are classified as either public charities or private foundations. Penalty excise taxes may be imposed under the Code when a public charity makes improper political expenditures (section 4955) or excess or disqualifying lobbying expenditures (secs. 4911 and 4912). However, the Code generally does not provide for the imposition of penalty excise taxes in cases where a 501(c)(3) public charity or a section 501(c)(4) social welfare organization engages in a transaction that results in private inurement. In such cases, the only sanction that specifically

¹⁴ See, e.g., “*Geisinger Health Plan v. Commission*,” 985 F.2d 1210 (3rd Cir. 1993) (holding that network model HMO did not qualify for section 501(c)(3) status because its activities did not primarily benefit the community).

¹⁵ See generally, GCM 39829 (August 30, 1990) (reviewing IRS position regarding HMOs).

¹⁶ Compare GCM 39862 (November 22, 1991) (transactions in which part of hospitals’ net revenue stream sold to physicians found to constitute private inurement) with PLR 9112006 (December 20, 1990) (incentive compensation plan in which all employees participate found to not jeopardize tax-exempt status of hospital).

¹⁷ Even where no prohibited private inurement exists, however, more than incidental private benefits conferred on individuals may result in the organization not being operated “exclusively” for an exempt purpose. See, e.g., *American Campaign Academy v. Commissioner*, 92 T.C. 1053 (1989).

is authorized under the Code is revocation of the organization's tax-exempt status.

Transactions engaged in by private foundations (but not public charities) are subject to special penalty excise taxes under the Code if the transaction is a prohibited "self-dealing" transaction (sec. 4941) or does not accomplish a charitable purpose (sec. 4945). Non-profit hospitals, and other nonprofit entities the principal purpose or functions of which are providing medical care, automatically are eligible for public-charity status and, thus, are not subject to the special penalty excise tax provisions governing private foundations.

Filing and public disclosure rules applicable to tax-exempt organizations

Tax-exempt organizations generally are required to file an annual information return (Form 990) with the IRS. Code section 6104 requires that a tax-exempt organization (other than a private foundation) make available for public inspection at the organization's principal office a copy of the organization's Form 990 (except for the names of contributors to the organization) for the three most recent taxable years. This public inspection requirement also extends to the organization's application to the IRS for recognition of tax-exempt status, the IRS determination letter, and certain other related documents.

Explanation of Provisions.—

New statutory requirements for tax-exempt health care service organizations

The bill would impose new requirements on tax-exempt organizations described in section 501(c)(3) or 501(c)(4) that have as their predominant activity the provision of "health care services."¹⁸ (The bill refers to such organizations as "applicable tax-exempt health care organizations.") The requirements, therefore, would apply to tax-exempt hospitals, clinics, nursing homes, old age homes, and HMOs. The new requirements would not apply to organizations whose predominant activities are non-health care service activities (e.g., an educational organization, if the predominant activities of the organization do not involve the delivery of health care services to patients). The new requirements would not apply to State and local governmental entities.

Under the bill, in addition to satisfying a community benefit standard, applicable tax-exempt health care organizations would be required to satisfy the following six requirements in order to be eligible for tax-exempt status.

(1) The organization must provide (directly or indirectly) significant "qualified outreach services." The term "qualified outreach services" would be defined as health care services, or related education or social services programs, provided either (a) in an area that is medically underserved with respect to such health care services (i.e., a health professional shortage area "HPSA" des-

¹⁸ The term "health care services" would mean—(i) any activity of providing medical care (as defined in section 213(d)(1)(A)) to individuals; (ii) any activity (such as nursing or old age home care) which is treated as accomplishing an exempt purpose of a 501(c)(3) organization solely because it is carried on as part of an activity described in (i) above; and (iii) insurance (that is not commercial-type insurance under section 501(m)) for activities described in (i) or (ii) above.

ignated by the Secretary of HHS or an area or population group reasonably determined by the organization, in a manner not inconsistent with Treasury Department regulations, to have a shortage of health professionals relative to the number of individuals needing such services in the area or population group) or (b) below cost to individuals otherwise unable to afford such services.¹⁹

(2) With the participation of community representatives, the organization must annually assess the health care and qualified outreach service needs of the community and develop a written plan that sets forth how the organization plans to meet those needs.

(3) The organization must be governed by an independent board of directors, at least 80 percent of the members of which receive no compensation (directly or indirectly) (a) for medical services performed in connection with the organization or (b) as an officer (including individuals having powers or responsibilities similar to those of officers) of the organization.²⁰

(4) The organization must not discriminate against individuals in the provision of health care services on the basis of whether the individual is insured by a government-sponsored health plan (e.g., Medicare or Medicaid).²¹

(5) The organization must not discriminate against individuals in the provision of emergency health care services on the basis of the individual's ability to pay.²²

(6) To the extent of its financial ability, the organization must not discriminate against individuals in the provision of medically necessary health care services (other than emergency services) on the basis of the individual's ability to pay.²³

The statutory requirements described above would not apply to an organization that provides health care services exclusively on an uncompensated basis, regardless of a patient's ability to pay.

Organizations that fail to satisfy one or more of the above new statutory requirements would be subject to revocation of their tax-exempt status and, in such event, would be ineligible to receive contributions that are deductible by the donor for Federal income, estate, or gift tax purposes. However, in lieu of revocation of tax-exempt status, the bill also provides for intermediate sanctions (described below) that could be imposed on organizations that fail to satisfy the new statutory requirements.

¹⁹The provision of insurance would constitute a "qualified outreach service" only if provided on a subsidized basis. An organization would demonstrate that it provides significant qualified outreach services on a facts-and-circumstances basis. An organization would have the option of directly furnishing such services or indirectly providing such services by making a grant or contribution to a donee organization that furnishes qualified outreach services.

²⁰However, independent board members could be compensated for services performed as a member of the board.

²¹Under the bill, the Secretary of the Treasury could prescribe safe-harbor regulations, under which nursing homes would be treated as satisfying this nondiscrimination requirement by accepting a specified proportion (e.g., 50 percent) of Medicaid patients. The Committee intends that an institution would not violate the nondiscrimination requirement if the institution cannot obtain State certification that is a prerequisite to accepting individuals insured by a government-sponsored health plan (e.g., Medicaid) due to a State moratorium on issuing such certification.

²²If an organization did not provide emergency services (e.g., it did not operate an emergency room), then it could not "discriminate" in the provision of such services and, therefore, would not be subject to this rule.

²³For purposes of this provision, insurance would not be a "medically necessary health care service." Consequently, requirements (4), (5), and (6) (above) effectively would not apply to an HMO that does not directly provide medical services (e.g., a network-model HMO exempt under Code section 501(c)(4)).

Effective Date.—The new statutory requirements governing applicable tax-exempt health care organizations would take effect on January 1, 1995, except the independent governance requirement (described above) would take effect on January 1, 1997.

HMO qualification under section 501(c)(3)

Under the bill, an HMO seeking tax-exempt status under section 501(c)(3) would be required to furnish substantially all of its primary care health services at its own facilities through health care professionals who do not provide substantial health care services other than on behalf of such organization. Thus, tax-exempt status under section 501(c)(3) would be available to an HMO only if it is organized according to a so-called “staff model” or “dedicated-group model.” In contrast, an HMO seeking tax-exempt status under section 501(c)(4) would not be required directly to furnish health care services at its own facility (but would be required to meet the requirements of section 501(m), discussed below).

Effective Date.—The provision would be effective on the date of enactment.

Tax-exempt status for regional alliances and certain parent organizations

If a State elects to establish regional alliances under the bill, then such regional alliances would be eligible for Federal tax-exempt status, provided that private inurement, lobbying, and political activity restrictions are satisfied (similar to present-law section 501(c)(3)). The regional alliances would not be eligible to use financing provided from the proceeds of tax-exempt bonds.

The bill further would clarify that, under present-law section 509(a), organizations that serve as parent holding companies for hospitals or medical research organizations could qualify as public charities rather than private foundations.

Effective Date.—These provisions would be effective on the date of enactment.

Extend private inurement prohibition to social welfare organizations

The bill would amend section 501(c)(4) explicitly to provide that if a social welfare organization or other organization described in that section has as its predominant activity the provision of health care services, such organization would be eligible for tax-exempt status only if no part of its net earnings inures to the benefit of any private shareholder or individual.²⁴

Effective Date.—The provision generally would be effective on June 30, 1994. However, under a special transition rule, the provision would not apply to inurement occurring prior to July 1, 1996, if such inurement results from a written contract that was binding on June 29, 1994, and at all times thereafter before such inurement occurred, and the terms of which have not materially changed.

²⁴ No inference is intended regarding application of the private inurement and private benefit tests to other organizations described in section 501(c)(4).

Intermediate sanctions for violations by tax-exempt health care service organizations

Violations of new statutory requirements for tax-exempt health care service organizations.—The bill would provide for intermediate sanctions in the form of excise tax penalties that may be imposed on “applicable tax-exempt health care organizations” that fail to satisfy the new statutory requirements (discussed above). Under the bill, “applicable tax-exempt health care organizations” would be defined as organizations described in section 501(c)(3) or section 501(c)(4) that have as their predominant activity the providing of health care services. Thus, an applicable tax-exempt health care organization could be subject to the intermediate sanction if it fails to comply with the bill’s requirements to provide significant qualified outreach services, prepare a community health care and outreach needs assessment and plan, be governed by an independent board, not discriminate against government health plan participants, not discriminate against patients needing emergency services based on their inability to pay, or provide other free medically necessary care to the extent of the organization’s financial ability.

Under the bill, organizations that fail to satisfy one or more of the new statutory requirements imposed on applicable tax-exempt health care organizations would be subject to a penalty excise tax in an amount equal to the greater of (1) \$25,000, or (2) five percent of the organization’s net investment income (including the net investment income of certain related, supporting organizations²⁵) for the taxable year.

The excise tax could be imposed by the IRS as an intermediate sanction in lieu of revocation of an organization’s tax-exempt status. Under the bill, if an organization can establish to the satisfaction of the Secretary of the Treasury that the violation was due to reasonable cause and not due to willful neglect and that the organization has taken measures to prevent future violations, then the excise tax shall be abated.

Effective Date.—The provision would take effect on January 1, 1995 (except an effective date of January 1, 1997 would apply for violations of the independent governance requirement).

Excess benefit transactions

The bill also would impose penalty excise taxes as an intermediate sanction in cases where an applicable tax-exempt health care organization (other than a private foundation) engages in an “excess benefit transaction.” In such cases, intermediate sanctions could be imposed on certain disqualified persons (i.e., insiders) who improperly benefit from an excess benefit transaction and on organization managers who participate in such a transaction knowing that it is improper.

An “excess benefit transaction” would be defined as: (1) any transaction in which an economic benefit is provided to, or for the

²⁵ For purposes of determining net investment income, such income of the following organizations would be taken into account: (1) an organization that is described in present-law section 509(a)(3) (A) or (B) with respect to an applicable health care organization, (2) an organization described in new section 509(a)(4) as added by the bill (see above), and (3) an entity that is organized and operated for the benefit of, and that directly or indirectly is controlled by, an applicable health care organization.

use of, any disqualified person if the value of the economic benefit provided to such person exceeds the value of consideration (including performance of services) received by the organization for providing such benefit; (2) lending of money or other extension of credit by an organization to, or for the use of, an organization manager; and (3) any transaction in which the amount of any economic benefit provided to, or for the use of, any disqualified person is determined in whole or in part by the gross or net income of one or more activities of the organization, provided that the transaction constitutes prohibited inurement under present-law section 501(c)(3) or under section 501(c)(4), as amended. Thus, "excess benefit transactions" subject to excise taxes would include transactions in which a disqualified person engages in a non-fair-market-value transaction with the organization or receives unreasonable compensation.²⁶ "Excess benefit transactions" also would include any lending of money (regardless of the terms of the loan) or other extension of credit made by an organization to one or more of its managers,²⁷ as well as financial arrangements under which a disqualified person receives payment based on the organization's gross or net income in a transaction that violates the present-law private inurement prohibition.

"Disqualified person" would mean any person who is (1) an "organization manager" (meaning any officer, director, or trustee of an organization or any individual having powers or responsibilities similar to those of officers, directors, or trustees) or (2) any individual (other than an organization manager) who is in a position to exercise substantial influence over the affairs of the organization.²⁸ In addition, "disqualified persons" would include certain family members and 35-percent owned entities²⁹ of any person described in (1) or (2) above, as well as any person who was a disqualified person at any time during the five-year period prior to the transaction at issue.

A disqualified person who benefits from an excess benefit transaction would be subject to a first-tier penalty tax equal to 25 percent of the amount of the excess benefit (i.e., the amount by which a transaction differs from fair-market-value, the amount of compensation exceeding reasonable compensation, the amount of a loan to an organization manager, or the amount of a prohibited trans-

²⁶ Existing tax law standards would apply in determining reasonableness of compensation and fair market value. The payment of personal expenses and benefits to disqualified persons, and non-fair-market-value transactions benefiting such persons, should be treated as compensation only if it is clear that the organization intended and made the payments as compensation for services. In determining whether such payments or transactions are, in fact, compensation, the relevant factors include whether the appropriate decision-making body approved the transfer as compensation in accordance with established procedures and whether the organization and the recipient reported the transfer as compensation on the relevant forms (i.e., the organization's Form 990, the Form W-2 provided by the organization to the recipient, the recipient's Form 1040, and other required returns).

²⁷ The Committee intends that this rule not apply to monetary advances made by an organization to cover travel (or similar) expenses incurred by an organization manager on behalf of the organization.

²⁸ The Committee intends that a person performing substantial medical services as a physician pursuant to an employment or other contractual relationship with the organization (or a related organization) generally will be treated as being in a position to exercise substantial influence over the affairs of the organization.

²⁹ Family members would be determined under present-law section 4926(d), except that such members also would include siblings (whether by whole or half blood) of the individual, and spouses of such siblings. "35-percent owned entities" would mean corporations, partnerships, and trusts or estates in which a disqualified person owns more than 35 percent of the combined voting power, profits interest, or beneficial interest.

action based on the organization's gross or net income). Organization managers who participate in an excess benefit transaction knowing that it is an improper transaction would be subject to a first-tier penalty tax of ten percent of the amount of the excess benefit (subject to a maximum amount of tax of \$10,000).

Additional, second-tier taxes could be imposed on a disqualified person if there is no correction of the excess benefit transaction within a specified time period.³⁰ In such cases, the disqualified person would be subject to a penalty tax equal to 200 percent of the amount of excess benefit. For this purpose, the term "correction" would mean undoing the excess benefit to the extent possible, establishing safeguards to prevent future such excess benefit, and, where fully undoing the excess benefit is not possible, taking such additional corrective action as prescribed by Treasury regulations.

The intermediate sanctions for "excess benefit transactions" could be imposed by the IRS in lieu of (or in addition to) revocation of an organization's tax-exempt status. If more than one disqualified person or manager is liable for a penalty excise tax, then all such persons would be jointly and severally liable for such tax. Under the bill, the IRS would have authority to abate the excise tax penalty (under present-law section 4962) if it is established that the violation was due to reasonable cause and not due to willful neglect and the transaction at issue was corrected within the correction period.

To prevent an organization from avoiding the penalty excise taxes through termination of its tax-exempt status, the bill also would impose a tax on applicable tax-exempt health care organizations that terminate their tax-exempt status. The amount of the tax would be equal to the lesser of (1) the aggregate tax benefits that an organization can substantiate that it has received from its exemption from tax under Code section 501(a), or (2) the value of the net assets of such organization.³¹ The Secretary of the Treasury would be permitted to abate all or a portion of the tax if an applicable tax-exempt health care organization distributes all of its net assets to one or more charitable organizations described in Code section 501(c)(3) that have been in existence for a continuous 5-year period. In addition, applicable tax-exempt health care organizations that are described in Code section 501(c)(4) would be permitted to distribute their net assets to one or more organizations described in Code section 501(c)(4) that have been in existence for a continuous 5-year period. An applicable health care organization would be permitted to terminate its exempt status only if it has paid the tax (or any portion thereof that is not abated) and the organization has notified the Secretary of its intent to terminate its exempt status (or the Secretary has made a final determination that such status has terminated).

Effective Date.—The provision generally would apply to excess benefit transactions occurring on or after June 30, 1994. The provision would not apply, however, to any transaction pursuant to a

³⁰ Correction would have to be made on or prior to the earlier of (1) the date of mailing of a notice of deficiency under section 6212 with respect to the first-tier penalty excise tax imposed on the disqualified person, or (2) the date on which such tax is assessed.

³¹ In calculating these amounts, rules similar to the rules applicable to private foundations set forth in Code section 507(d), (e), and (f) would apply.

written contract for the performance of personal services which was binding on June 29, 1994, and at all times thereafter before such transaction occurred, and the terms of which have not materially changed.

Additional filing and public disclosure rules

Disclosure of community benefit and outreach services plan.—Under the bill, applicable tax-exempt health care organizations would be required to make available to the general public and the IRS the written community health care and outreach service needs plan (required above), in the same manner that their annual information return (Form 990) is required to be available under present law. The bill also provides that such organizations would be required to furnish, as part of their annual Form 990, information regarding their implementation of the community health care and outreach service need plan for the year (including unrecovered costs and revenues foregone in furtherance of such plan).

Reporting of excise tax penalties and excess benefit transactions.—Applicable tax-exempt health care organizations would be required to disclose on their Form 990 any penalty taxes (described above) paid or imposed during the year due to the organization's failure to meet the new statutory requirements. Such organizations also would be required to disclose such information as the Secretary of the Treasury may require with respect to "excess benefit transactions" (also described above) and any other excise tax penalties paid during the year under present-law sections 4911 (excess lobbying expenditures), 4912 (disqualifying lobbying expenditures), or 4955 (political expenditures), including the amount of the excise tax penalties paid with respect to such transactions, the nature of the activity, and the parties involved.³²

Furnishing copies of documents.—The bill also provides that applicable tax-exempt health care organizations would be required to comply with requests from individuals who seek a copy of the organization's written community health care and outreach services plan, a copy of the Form 990, or the organization's application for recognition of tax-exempt status and certain related documents. Upon such a request, the organization would be required to supply copies without charge other than a reasonable fee for reproduction and mailing costs. If so requested, copies must be supplied of the community health care and outreach services needs plans or Forms 990 for any of the organization's three most recent taxable years. If the request for copies were made in person, then the organization would have to immediately provide such copies. If the request for copies were made other than in person (e.g., by mail or telephone), then copies would have to be provided within 30 days. However, an organization could be relieved, for a limited period of time, of its obligation to provide copies if the Secretary of the

³²The Committee intends that the penalties applicable to failure to file a timely, complete, and accurate return apply for failure to comply with these requirements. Accordingly, the Committee urges the IRS to be particularly attentive to the reporting of excise tax assessments due to violations of the requirements for tax exemption and to report to the Committee annually on such excise tax assessments. The Committee further intends that the IRS implement its plan to require additional Form 990 reporting regarding (1) changes to the governing board or the certified public accounting firm, (2) such information as the Secretary may require relating to professional fundraising fees paid by the organization, and (3) aggregate payments (by related entities) in excess of \$100,000 to the highest-paid employees.

Treasury determined, upon application by the organization, that the organization was subject to a harassment campaign such that waiver of the obligation to provide copies would be in the public interest.

Fundraising solicitations.—The bill further would require that each fundraising solicitation made by (or on behalf of) an applicable tax-exempt health care organization must contain an express statement, in a conspicuous and easily recognizable format, that the organization's Forms 990 are available to individuals upon request. The term "fundraising solicitation" would be defined (as under present-law section 6113(c)) as any solicitation of contributions or gifts that is made in written or printed form, by television or radio, or by telephone, but would not include any letter or telephone call that is not part of a coordinated fundraising campaign soliciting more than ten persons during the calendar year. Failure to make the required disclosure in a fundraising solicitation would subject the organization to a penalty of \$100 for each day on which the failure occurred. However, no penalty could be imposed with respect to a failure if it is shown that such failure was due to reasonable cause. The bill generally would limit the maximum penalty to \$10,000 for all such failures by an organization during any calendar year.³³

Effective Date.—The filing and disclosure provisions governing applicable tax-exempt health care organizations would take effect on January 1, 1995.

Sec. 6. Treatment of Nonprofit Health Care Organizations

Present Law.—Section 501(m) provides that an organization described in section 501(c)(3) or 501(c)(4) of the Code is exempt from tax only if no substantial part of its activities consists of providing "commercial-type insurance." In the case of an organization that is exempt from tax after this rule is applied, the activity of providing commercial-type insurance is treated as a taxable unrelated trade or business, and the tax is determined by applying the rules applicable to insurance companies. Commercial-type insurance generally includes any insurance of a type provided by commercial insurance companies. Present law provides that commercial-type insurance does not include incidental health insurance provided by a health maintenance organization (HMO) of a kind customarily provided by an HMO (sec. 501(m)(3)(B)).³⁴ The statute does not specify particular types of activities that satisfy this rule.

Explanation of Provision.—Under the bill, the provision of (or the arranging for the provision of) medical care on a prepaid basis by an HMO would not be treated as providing commercial-type insurance if and only if such care is: (1) care provided by the organization to its members at its own facilities through health professionals who do not provide substantial health care services other

³³ However, if a failure to comply with the disclosure requirement for solicitations were due to intentional disregard, then the \$10,000 limitation would not apply, and the penalty for each day on which such an intentional failure occurred would be the greater of (1) \$1,000 or (2) 50 percent of the aggregate cost of the solicitations which occurred on such day and with respect to which there was intentional disregard of the disclosure requirement.

³⁴ The Internal Revenue Service has interpreted these provisions with respect to HMOs in G.C.M. 39828 (August 30, 1990); G.C.M. 39829 (August 30 1990); and G.C.M. 39830 (August 30, 1990).

than on behalf of the organization; (2) care provided by a health care professional to a member of the organization on a basis under which substantially all of the risks with respect to rates of utilization by the member is assumed by the provider of such care; (3) care other than primary care provided to a member pursuant to a referral by the HMO; (4) emergency care provided to a member at a location outside the member's area of residence; or (5) care which the organization reasonably expected to be provided to a member as specified in (1), (2) or (3) above, but which is not so provided, pursuant to the "out-of-network" option³⁵ required to be offered by HMOs by section 2219(d) of the Social Security Act (as added by the bill).

For example, an HMO's provision of care would fall within the first category above, in the case of a staff or dedicated group model HMO that hires health care providers (as employees or independent contractors) to provide medical care exclusively to HMO members at the HMO's facilities.

An HMO's provision of (or arranging for provision of) care would fall within the second category above, if the HMO pays health care professionals on a fixed or capitated basis, where such payments are based on the number of members served by the health care professional, but not on the extent of services provided to a member.

The requirement that substantially all of the risks of rates of utilization of the care provider's services by members be borne by the provider is intended to limit the use of payment arrangements that do not shift substantially all the risk to the provider. For example, an HMO that is tax-exempt under section 501(c)(4) and makes capitated payments to a network of health care professionals in a particular area generally is not treated as providing commercial-type insurance under the provision. By contrast, assume the HMO expands its operation to a nearby area, and it chooses to do so by arranging to provide medical care through a network of physicians in that area on a fee-for-service basis. The HMO would be treated as providing commercial-type insurance. As under present law, depending on the substantiality of the activity of providing commercial-type insurance, the HMO would either be subject to tax on unrelated trade or business income with respect to the activity, or could become ineligible for tax-exempt status.

An HMO's provision of (or arranging for provision of) care would fall within the third category, above, if care other than primary care is provided to a member pursuant to a referral by the HMO (including for this purpose its health care professionals), or approval or ratification by the HMO.

The fifth category is intended to reconcile the requirement of section 2219(d) of the Social Security Act (as added by the bill) that managed care plans, including HMOs, must offer an out-of-network option, with the limitation on providing commercial-type insurance by tax-exempt HMOs. The fifth category is based on the assumption that an HMO generally expects a member to utilize medical

³⁵ As required by section 2219(d) of the Social Security Act, as added by the bill, the "out-of-network" option to be provided by all managed care plans (including HMOs) would require a managed care plan to provide coverage for items and services covered under the guaranteed national benefit package, if provided by a provider who is not a member of the plan's provider network. Such coverage would be subject to a cost-sharing schedule to be determined by the Secretary of HHS.

care through arrangements described in the first, second or third categories, above, and that utilization of the out-of-network option is expected to be small by comparison.³⁶ Thus, for example, if an organization purporting to be an HMO provides or arranges to provide medical care clearly using an insufficient number of health care professionals, or other major insufficiencies, and a significant portion of its payments to health care professionals arise under the out-of-network option utilized by members, then the organization may be treated as providing commercial-type insurance under the provision.

Effective Date.—The provision would be effective on the date of enactment.

Sec. 7. Tax Treatment of Taxable Organizations Providing Health Insurance and Other Prepaid Health Care Services

Present Law.—Under present law, no special rule provides that taxable health maintenance organizations (HMOs), or organizations similar to them, are treated as property and casualty insurance companies for Federal tax purposes. The tax treatment of a taxable HMO (e.g., an HMO organized on a for-profit basis) depends largely on the extent to which it qualifies as an insurance company. At present, the majority of HMOs are taxable (rather than tax-exempt). Many, but not all, of these organizations have determined their Federal tax on the assumption that they qualify as property and casualty insurance companies.

In determining taxable income, property and casualty insurance companies include (among other income and gains) underwriting income (sec. 832(b)(1)). In calculating underwriting income, a property and casualty insurance company generally may take a reserve deduction for a portion (80 percent) of the increase for the year in its unearned premiums and for the discounted amount of losses incurred (including incurred but not reported losses) (secs. 832(b) (4) and (5) and 846). These deductions may not reflect the “all events” test or the economic performance requirements that generally apply to accrual-method taxpayers.

Explanation of Provision.—The bill would expand the scope of organizations treated as taxable property and casualty insurance companies. Under the provision, any organization that is not tax-exempt, is not a life insurance company, is not an organization to which section 833 applies, and whose primary and predominant business activity during the taxable year falls in one of three categories, would be treated as a property and casualty insurance company for Federal tax purposes. In applying this provision, an organization’s “primary and predominant” business activity is intended to mean the activity which constitutes more than half of the organization’s business activities, determined on a reasonable basis (for example, as a fraction of gross revenues from all business activities).

The three categories of activities would be: (1) issuing accident and health insurance contracts or reinsuring accident and health

³⁶ This expectation (i.e., that care is reasonably expected to be provided to a member under categories (1), (2) or (3)) generally is to be determined without regard to an actuarial determination of the probable utilization of the out-of-network option.

risks; (2) operating as an HMO; or (3) entering into arrangements under which fixed payments or premiums are received by the organization as consideration for providing or arranging for the provision of health care services and substantially all the risks of the rates of utilization of such services is assumed by the provider of such services. No inference is intended that taxable organizations (whether or not treated as insurance companies under applicable State law or regulation) whose activities consist of traditional insurance activities such as arranging for the provision of medical care, or reimbursing for medical care, on a fee-for-service basis, are not insurance companies for Federal tax purposes.

The "primary and predominant" requirement would be modified in the case of organizations that have, as a material business activity, the issuing or reinsurance of accident and health insurance contracts. For such organizations, the administering of accident and health insurance contracts is treated under the bill as part of such business activity for purposes of determining whether the organization's activities fall within the scope of category (1) above.

It is anticipated that, in the case of a staff or dedicated group model HMO (where the HMO hires health care professionals either as employees or independent contractors), no loss reserve deduction for incurred but not reported (IBNR) losses would be allowable with respect to such health care professionals' services. In general, in those circumstances, utilization of services of such health care professionals is or can be known by the end of the HMO's taxable year. On the other hand, to the extent the period of health insurance coverage of members of the HMO extends beyond the end of the HMO's taxable year (e.g., where premiums or prepayments for health care services are not due or paid monthly, but rather are due or paid annually or quarterly over a period other than the HMO's taxable year), then a deduction with respect to the increase in unearned premiums for the year (reduced as required by present law) would be appropriate.

Effective Date.—The provision would be effective for taxable years beginning after December 31, 1994. A transition rule provides that, for an organization other than one which (1) treats itself as subject to tax as a property and casualty insurance company on its original Federal tax return for taxable years beginning in 1992 through 1994, or (2) is tax-exempt for its last taxable year beginning before 1995, the change made by the provision is treated as a change in method of accounting, and adjustments under section 481 are taken into account for its first taxable year beginning after December 31, 1994. It is not intended that an organization described under the provision that received approval to change its method of accounting before December 31, 1994 so as to be treated as a property and casualty insurance company for Federal tax purposes be subject to the rule under the provision relating to taking into account in one year the adjustments under section 481, i.e., such an organization's section 481 adjustments would not be accelerated by the provision.

Under the transition rule, in the case of a taxable organization that is treated as subject to the requirements of section 848 (relating to capitalization of policy acquisition expenses) for its first taxable year beginning after December 31, 1994, any adjustment at-

tributable to not being treated as subject to section 848 in a prior year would be treated as attributable to a change in method of accounting, and taken into account for its first taxable year beginning after December 31, 1994.

Sec. 8. Organizations Subject to Section 833

Present Law.—An organization described in sections 501(c)(3) or (4) of the Code is exempt from tax only if no substantial part of its activities consists of providing commercial-type insurance (sec. 501(m)). Special rules apply to certain eligible health insurance organizations. Eligible health insurance organizations are (1) Blue Cross or Blue Shield organizations existing on August 16, 1986, which have not experienced a material change in structure or operations since that date, and (2) other organizations that meet certain community-service-related requirements and substantially all of whose activities involve the providing of health insurance. Section 833 provides that eligible organizations are generally treated as stock property and casualty insurance companies.

The special deduction for eligible organizations is equal to 25 percent of the claims and expenses incurred during the year, less the adjusted surplus at the beginning of the year. This deduction is calculated by computing surplus, taxable income, claims incurred, expenses incurred, tax-exempt income, net operating loss carryovers, and other items attributable to health business. The deduction may not exceed taxable income attributable to health business for the year (calculated without regard to this deduction).

In addition, section 833 eliminates, for eligible organizations, the 20-percent reduction in unearned premium reserves that applies generally to all property and casualty insurance companies.

Explanation of Provision.—The bill would apply the special rules under section 833 to the same extent they are provided to certain existing Blue Cross or Blue Shield organizations, in the case of any organization that (1) is not a Blue Cross or Blue Shield organization existing on August 16, 1986, and (2) otherwise meets the requirements of section 833(c)(2) (including the requirement of no material change in operations or structure since August 16, 1986). Under the provision, an organization qualifies for this treatment only if (1) it is not a health maintenance organization and (2) it is organized under and governed by State laws which are specifically and exclusively applicable to not-for-profit health insurance or health service type organizations.

Effective Date.—The provision would be effective for taxable years beginning after December 31, 1986.

Sec. 9. Tax Exemption for High-Risk Insurance Pools (sec. 11406 of the bill and sec. 501(c)(27) of the Code)

Present Law.—No provision of present law specifically provides for tax-exempt status for organizations providing health insurance coverage to persons unable to obtain health insurance coverage in the private insurance market because of health conditions. Section 501(c)(6) of the Code provides for tax-exempt status for business leagues and certain other organizations not organized for profit and no part of the net earnings of which inures to the benefit of any

private shareholder or individual. Section 501(c)(4) provides for tax-exempt status for certain civic leagues or organizations not organized for profit but operated exclusively for the promotion of social welfare; however, such an organization may be exempt only if no substantial part of its activities consists of providing commercial-type insurance. In the case of a State or any political subdivision of a State, present law provides an exclusion for income derived from the exercise of any essential governmental function (sec. 115). Health insurance risk pools have been established in some States, and some of them (depending on their mode of organization and sources of funding) have been determined by the Internal Revenue Service to be exempt from tax under section 501(c)(6), or claim that income is excludable under section 115.

Explanation of Provision.—The provision would expand the list of organizations exempt from tax under section 501(c) for any corporation, association, or similar legal entity created by any State or political subdivision thereof to establish a risk pool to provide health insurance coverage to any person unable to obtain health insurance coverage in the private insurance market because of health conditions. No part of the net earnings of the organization could inure to the benefit of any private shareholder, member, or individual. The provision would expire with respect to taxable years beginning after December 31, 1997 (coordinating with the phase-in of insurance reforms under the bill).

Effective Date.—The provision applies to taxable years beginning after December 31, 1989, and before January 1, 1998.

Subtitle E. Treatment of accelerated death benefits under life insurance contracts

Present Law.—

Treatment of amounts received under a life insurance contract

If a contract meets the definition of a life insurance contract, gross income does not include insurance proceeds that are paid pursuant to the contract by reason of the death of the insured (sec. 101(a)). In addition, the undistributed investment income (“inside buildup”) earned on premiums credited under the contract is not subject to current taxation to the owner of the contract. The exclusion from income applies regardless of whether the death benefits are paid as a lump sum or otherwise.

Amounts received under a life insurance contract (other than a modified endowment contract) prior to the death of the insured are includible in the gross income of the recipient to the extent that the amount received exceeds the taxpayer’s investment in the contract (generally, the aggregate amount of premiums paid less amounts previously received that were excluded from gross income).

Treatment of amounts received under a failed life insurance contract

If a contract fails to meet the definition of a life insurance contract, inside buildup on the contract is generally subject to tax. Under section 7702(g), income on the contract for the year in which a contract fails to meet the definition of life insurance (and income on the contract for all prior years) generally is treated as ordinary

income received or accrued by the holder during that year. For this purpose, income on the contract is the excess of (1) the increase in the net surrender value of the contract during the taxable year and the cost of the life insurance protection provided during the taxable year, over (2) the premiums paid under the contract during the taxable year (sec. 7702(g)(1)(B)). In addition, a portion of the amount paid by reason of the death of the insured may be includible in income; that is, only the excess of the amount paid by reason of the death of the insured over the net surrender value of the contract is treated as life insurance proceeds eligible for the exclusion provided under section 101 (sec. 7702(g)(2)).

Requirements for a life insurance contract

To qualify as a life insurance contract for Federal income tax purposes, a contract must be a life insurance contract under the applicable State or foreign law and must satisfy either of two alternative tests: (1) a cash value accumulation test, or (2) a test consisting of a guideline premium requirement and a cash value corridor requirement (sec. 7702(a)).

Proposed regulations on accelerated death benefits

The Treasury Department has issued proposed regulations³⁷ under which certain "qualified accelerated death benefits" paid as a result of the terminal illness of the insured would be treated as paid by reason of the death of the insured and therefore, under the proposed regulations, would qualify for the present-law exclusion from income. In addition, the proposed regulations would permit an insurance contract that includes a qualified accelerated death benefit rider to qualify as a life insurance contract under section 7702.

Under the proposed regulations, a benefit would qualify as a qualified accelerated death benefit only if it meets three requirements. First, the qualified accelerated death benefit can be payable only if the insured becomes terminally ill. Second, the amount of the accelerated benefit must equal or exceed the present value of the reduction in the death benefit otherwise payable. Third, the cash surrender value and the death benefit under the policy must be proportionately reduced as a result of the accelerated benefit payment. For purposes of the proposed regulations, an insured person would be treated as terminally ill if he or she has an illness that, despite appropriate medical care, the insurer reasonably expects to result in death within 12 months from the date of payment of the accelerated death benefit. The proposed regulations would not explicitly require a doctor's certification as to the patient's condition.

Under the proposed regulations, the maximum permissible discount rate would be the greater of (1) the applicable Federal rate (AFR) that applies under the discounting rules for property and casualty insurance loss reserves, or (2) the interest rate applicable to policy loans under the contract.

Discounting would be calculated assuming the death benefit would have been paid 12 months after the payment of the accelerated death benefit.

³⁷ Prop. Treas. Reg. Secs. 1.101-8, 1.7702-0, 1.7702-2, and 1.7702A-1 (December 15, 1992).

Explanation of Provision.—The bill would provide an exclusion from gross income for certain amounts received under a life insurance contract if the insured under the contract is terminally ill. For this purpose, an individual would be considered terminally ill if the insurer determines, after receipt of an acceptable certification by a licensed physician, that the individual has an illness or physical condition that is reasonably expected to result in death within 12 months of the certification.

The exclusion under the bill would be applicable only if two requirements are met. First, under a present value test, the amount received must equal or exceed the present value of the reduction in the death benefit otherwise payable under the life insurance contract. Second, under a ratio test, the payment of the amount must not reduce the cash surrender value of the contract proportionately more than the death benefit payable under the contract. In other words, the percentage derived by dividing the cash surrender value of the contract immediately after the distribution by the cash surrender value of the contract immediately before the distribution must equal or exceed the percentage derived by dividing the death benefit payable immediately after the distribution by the death benefit payable immediately before the distribution. The amount received is intended to include a series of payments.

For purposes of the present value test, the present value of the reduction in the death benefit is determined by reference to a maximum permissible discount rate, and by assuming that the death benefit would have been paid on the date that is 12 months from the date of the physician's certification. The maximum permissible discount rate is the highest of the following three interest rates: (1) the 90-day Treasury bill yield, (2) Moody's Corporate Bond Yield Average-Monthly Average Corporates (or any successor rate) for the month ending two months before the date the rate is determined, or (3) the rate used to determine cash surrender values under the contract during the applicable period plus 1 percent per annum.

For example, assume that an insured is certified as being terminally ill on January 1, 1995. Assume also that the maximum permissible discount rate is 10 percent and that the cash surrender value of the contract is \$100,000 and the death benefit payable is \$500,000. Finally, assume that an accelerated death benefit is paid on July 1, 1995 which reduces the death benefit payable under the contract by \$200,000 (i.e., from \$500,000 to \$300,000). Under these facts, the applicable discount period would be six months (i.e., the period between July 1, 1995 and January 1, 1996)³⁸ and thus, the amount of the accelerated death benefit paid must equal or exceed \$190,280 (i.e., the \$200,000 reduction in the death benefit payable discounted at 10 percent for six months). In addition, the cash surrender value of the contract after distribution of the accelerated death benefit must equal or exceed \$60,000.

If the accelerated death benefit under the contract is paid pursuant to a lien against the death benefit rather than an actual reduction in the death benefit on a discounted basis, then the amount of the lien, and interest charges relating to the lien, would be taken

³⁸ January 1, 1996 is the date 12 months after the date of the physician's certification.

into account as follows, so as to achieve parity between use of the lien method and use of a discounted payment. First, for purposes of applying the present value test and the ratio test (described above), the amount of the lien is treated as a reduction in the death benefit and in the cash surrender value. Any interest charges in connection with the lien that could encumber the cash surrender value or the death benefit in the future are also treated as a reduction in the cash surrender value and the death benefit at the time of the accelerated benefit payment. Second, for purposes of applying the present value test, the interest charges with respect to a lien cannot exceed the discount that would have been permitted had the accelerated benefit been paid on a discounted basis instead of by use of a lien. Thus, the rate of any interest charged could not exceed the maximum permissible discount rate, and the lien may not encumber the cash surrender value proportionately more than it encumbers the death benefit.

The provision does not apply in the case of an amount paid to any taxpayer other than the insured, if such taxpayer has an insurable interest by reason of the insured being a director, officer or employee of the taxpayer, or by reason of the insured being financially interested in any trade or business carried on by the taxpayer.

For life insurance company tax purposes, the provision treats a qualified accelerated death benefit rider to a life insurance contract as life insurance. A qualified accelerated death benefit rider is any rider on a life insurance contract if the only payments which can be made under the rider are payments that are excludable under this provision.

Effective Date.—The provision generally would apply to amounts received after the date of enactment. However, the present value test (i.e., the rule that the amount received as an accelerated death benefit must equal or exceed the present value of the reduction in the death benefit) would not apply to any amount received before January 1, 1995. The issuance of a qualified accelerated death benefit rider to a life insurance contract would not be treated as a modification or material change of the contract (and is not intended to affect the issue date of any contract under section 101(f)). The provision treating a qualified accelerated death benefit rider as life insurance for life insurance company tax purposes would be effective on January 1, 1995.

Subtitle F. Employment status provisions

Sec. 10. Employment Status Proposal Required from Department of the Treasury (sec. 11601 of the bill)

Present Law.—In general, the determination of whether an employer-employee or independent contractor relationship exists for Federal tax purposes is made under a common-law test. Under this test, an employer-employee relationship generally exists if the person contracting for the services has the right to control not only the result of the services, but also the means by which that result is accomplished (Treas. Reg. sec. 31.3401(c)-(1)(b)). Whether the requisite control exists is determined based on the facts and circumstances. The Internal Revenue Service (IRS) uses a 20-factor

test for this purpose. Rev. Rul. 87-41, 1987-1 C.B. 296. In addition to the common-law test, there are statutory provisions classifying certain workers as employees or independent contractors for certain purposes.

In the late 1960s, the IRS increased enforcement of the employment tax laws, and controversies developed between the IRS and taxpayers as to whether businesses had correctly classified certain workers as independent contractors rather than as employees. In response to this problem, Congress enacted section 530 of the Revenue Act of 1978 ("section 530"), which generally permits a taxpayer to treat an individual as not being an employee for employment tax purposes regardless of the individual's actual status under the common-law test, unless the taxpayer has no reasonable basis for such treatment and if certain additional requirements are satisfied. Section 530 does not apply in the case of an individual who, pursuant to an arrangement between the taxpayer and another person, provides services for such other person as an engineer, designer, drafter, computer programmer, systems analyst, or other similarly skilled worker engaged in a similar line of work.

Section 530 does not apply for income tax purposes. Thus, the determination of whether an individual is an employee for income tax purposes is made without regard to section 530.

Explanation of Provision.—The provision would direct the Secretary of the Treasury to submit a legislative proposal relating to the classification of workers as employees or independent contractors to the tax writing committees of the Congress by January 1, 1996.

Effective Date.—The provision would be effective on the date of enactment.

Sec. 11. Increase in Penalties Relating to Reporting of Payments for Services

Present Law.—

Information reporting requirements (secs. 6041(a) and 6041A(a))

Under the Code, a person engaged in a trade or business who makes payments during the calendar year of \$600 or more to a person for rents, salaries, wages, premiums, annuities, compensations, remunerations, emoluments, or other fixed or determinable gains, profits, and income, must file an information return with the Internal Revenue Service ("IRS") reporting the amount of such payments, as well as the name, address and taxpayer identification number of the person to whom such payments were made (sec. 6041(a)).³⁹ A similar statement must also be furnished to the person to whom such payments were made (sec. 6041(d)).

The Code contains an additional provision requiring that a service recipient (i.e., a person for whom services are performed) engaged in a trade or business who makes payments of remuneration in the course of that trade or business to any person for services performed must file with the IRS an information return reporting

³⁹ A number of exceptions to this requirement are provided in Treasury regulations. In addition, to the extent the general information reporting requirements of this provision overlap specific information reporting requirements elsewhere in the Code, taxpayers are generally required to report only once, under the more specific information reporting provision.

such payments (and the name, address, and taxpayer identification number of the recipient) if the remuneration paid to the person during the calendar year is \$600 or more (sec. 6041A(a)). A similar statement must also be furnished to the person to whom such payments were made (sec. 6041A(e)).

Failure to file correct information returns (sec. 6721)

Any person that fails to file a correct information return⁴⁰ with the IRS on or before the prescribed filing date is subject to a penalty that varies based on when, if at all, the correct information return is filed. If a person files a correct information return after the prescribed filing date but on or before the date that is 30 days after the prescribed filing date, the penalty is \$15 per return, with a maximum penalty of \$75,000 per calendar year. If a person files a correct information return after the date that is after 30 days after the prescribed filing date but on or before August 1 of that year,⁴¹ the penalty is \$30 per return, with a maximum penalty of \$150,000 per calendar year. If a correct information return is not filed on or before August 1, the amount of the penalty is \$50 per return, with a maximum penalty of \$250,000 per calendar year.

There is a special rule for de minimis failures to include the required, correct information. This exception applies to incorrect information returns that are corrected on or before August 1. Under the exception, if an information return is originally filed without all the required information or with incorrect information and the return is corrected on or before August 1, then the original return is treated as having been filed with all of the correct required information. The number of information returns that may qualify for this exception for any calendar year is limited to the greater of (1) 10 returns or (2) one-half of one percent of the total number of information returns that are required to be filed by the person during the calendar year.

In addition, there are special, lower maximum levels for this penalty for small businesses. For this purpose, a small business is any person having average annual gross receipts for the most recent 3 taxable years ending before the calendar year that do not exceed \$5 million. The maximum penalties for small businesses are: \$25,000 (instead of \$75,000) if the failures are corrected on or before 30 days after the prescribed filing date; \$50,000 (instead of \$150,000) if the failures are corrected on or before August 1; and \$100,000 (instead of \$250,000) if the failures are not corrected on or before August 1.

If a failure to file a correct information return with the IRS is due to intentional disregard of the filing requirement, the penalty for each such failure is increased to the greater of \$100 or 10 percent⁴² of the amount required to be reported correctly, with no limitation on the maximum penalty per calendar year (sec. 6721(e)). The increase in the penalty applies regardless of whether a cor-

⁴⁰ This term is defined in sec. 6742(d)(1), and refers to certain information reporting requirements in the Code, including secs. 6041(a) and 6041A(a).

⁴¹ Subsequent references to August 1 herein means August 1 of the year that includes the prescribed filing date.

⁴² This percentage varies depending upon the type of information return. With respect to information returns required under sections 6041(a) and 6041A(a), the applicable percentage is 10 percent (sec. 6721(e)(2)).

rected information return is filed, the failure is de minimis, or the person subject to the penalty is a small business.

Failure to furnish correct payee statements (sec. 6722)

Any person that fails to furnish a correct payee statement⁴³ to the person to whom the statement is required to be furnished on or before the prescribed due date is subject to a penalty of \$50 per statement, with a maximum penalty of \$100,000 per calendar year. If the failure to furnish a correct payee statement is due to intentional disregard of the requirement, the penalty increases to \$100 per statement or, if greater, 10 percent⁴⁴ of the amount required to be shown on the statement, with no limitation on the maximum penalty per calendar year.

Failure to comply with other information reporting requirements (sec. 6723)

Any person that fails to comply with other specified information reporting requirements on or before the prescribed date is subject to a penalty of \$50 for each failure, with a maximum penalty of \$100,000 per calendar year. The information reporting requirements specified for this purpose include any requirement to include a correct taxpayer identification number on a return, a statement, or any other document (other than an information return or payee statement) and any requirement to furnish a correct taxpayer identification number to another person (Treas. Reg. sec. 301-6723-1(a)(4)).

Waiver, definitions, and special rules (sec. 6724)

Any of the information reporting penalties may be waived if it is shown that the failure to comply is due to reasonable cause and not to willful neglect. For this purpose, reasonable cause exists if (1) there are significant mitigating factors for the failure, such as the fact that a person has an established history of complying with the information reporting requirements, or the failure was caused by events beyond the person's control, and (2) the person acted in a responsible manner both before and after the failure occurred (Treas. Reg. sec. 301-6724-1(a)(2)).

Explanation of Provision.—The bill would modify the penalty for failure to file correct information returns with respect to two types of information returns: (1) information returns under section 6041(a), but only if such returns relate to payments to any person for services performed by such person (other than as an employee);⁴⁵ and (2) returns regarding remuneration for services under section 6041A(a). In general, both of these sections of the Code relate to information returns with respect to payments made to non-employees, such as independent contractors.⁴⁶

⁴³ This term is defined in sec. 6724(d)(2), and refers to certain information reporting requirements in the Code, including secs. 6041(d) and 6041A(e).

⁴⁴ Five percent for several types of statements.

⁴⁵ Thus, the provision would not apply to information returns filed under section 6041(a) that do not report payments for services.

⁴⁶ Employers are required to provide information with respect to wages paid to their employees on Form W-2 under section 6051; consequently, those information returns would not be affected by the bill.

In general, the bill would increase the penalty for failure to file specified information returns correctly on or before August 1 from \$50 for each return to the greater of \$50 or 5 percent of the amount required to be reported correctly but not so reported. The \$250,000 maximum penalty for failures to file correct information returns during any calendar year would continue to apply under the bill.

The bill also would provide an exception to this increase where substantial compliance has occurred. Under the bill, this exception would apply with respect to a calendar year if the aggregate amount that is timely and correctly reported under sections 6041(a) and 6041A(a) with respect to services for that calendar year is at least 97 percent of the aggregate amount required to be reported under these two sections of the Code with respect to services for that calendar year. If this exception applies, the present-law penalty of \$50 for each return would continue to apply.

The bill would not affect the following provisions of present law: (1) the reduction in the \$50 penalty where correction is made within a specified period; (2) the exception for de minimis failures; (3) the lower limitations for persons with gross receipts of not more than \$5,000,000; (4) the increase in the penalty in cases of intentional disregard of the filing requirement; (5) the penalty for failure to furnish correct payee statements under section 6722; (6) the penalty for failure to comply with other information reporting requirements under section 6723; and (7) the reasonable cause and other special rules under section 6724.

Effective Date.—The provision would apply to information returns the due date for which (without regard to extensions) is more than 30 days after the date of enactment.

Subtitle G. Tax treatment of funding of retiree health benefits

Present Law.—Under present law, employer-provided post-retirement medical benefits are generally excludable from the gross income of a plan participant or beneficiary. In addition, an employer may deduct contributions, within limits, made to a welfare benefit fund for retiree health and life insurance benefits of its employees. A welfare benefit fund is, in general, any fund that is part of a plan of an employer, and through which the employer provides welfare benefits to employees or their beneficiaries.

Contributions by an employer to a welfare benefit fund are not deductible under the usual income tax rules, but if they otherwise would be deductible under the usual rules (e.g., if they are ordinary and necessary business expenses), the contributions are deductible within limits for the taxable year in which such contributions are made to the fund.

The amount of the deduction otherwise allowable to an employer for a contribution to a welfare benefit fund for any taxable year may not exceed the qualified cost of the fund for the year. The qualified cost of a welfare benefit fund for a year is the sum of (1) the qualified direct cost of the fund for the year and (2) the addition (within limits) to the qualified asset account under the fund for the year, reduced by (3) the after-tax income of the fund.

A qualified asset account under a welfare benefit fund is an account consisting of assets set aside to provide for the payment of disability payments, medical benefits, supplemental unemployment

compensation benefits or severance pay benefits, or life insurance benefits. Under present law, an account limit is provided for the amount in a qualified asset account for any year.

The account limit for any taxable year may include a reserve to provide certain post-retirement medical and life insurance benefits. This limit allows amounts reasonably necessary to accumulate reserves under a welfare benefit plan so that the liabilities for post-retirement medical and life insurance benefits with respect to a group of employees can be prefunded over the working lives of such employees.

Under present law, if an employer maintains a welfare benefit fund that provides a disqualified benefit during any taxable year, the employer is subject to an excise tax equal to 100 percent of the disqualified benefit. A disqualified benefit includes (1) a benefit provided to a key employee other than from a separate account required to be established for such an employee, (2) any post-retirement medical or life insurance benefit that is provided in a discriminatory manner, and (3) any portion of a welfare benefit fund reverting to the employer.

Explanation of Provision.—Under the provision, the minimum period during which the cost of post-retirement medical and life insurance coverage could be funded under a welfare benefit fund would be at least 10 years. Thus, an employer would be permitted to deduct the costs of funding such coverage on a level basis over the working lives of covered employees, but not over a period of less than 10 years.

The provision would clarify that a reserve to provide post-retirement medical and life insurance benefits under a welfare benefit plan must be maintained as a separate account. In addition, any payment from the separate account required to be maintained for post-retirement medical and life insurance benefits that is not used to provide a post-retirement medical or life insurance benefit would be included in the list of disqualified benefits for which the employer is subject to a 100-percent excise tax.

Effective Dates.—The provision relating to reserves for post-retirement medical and life insurance benefits under welfare benefit plans would be effective for contributions paid or accrued after December 31, 1994, in taxable years ending after that date. The provision requiring that the reserve for post-retirement medical and life insurance benefits be maintained as a separate account would be effective for contributions paid or accrued after the date of enactment, in taxable years ending after that date.

Subtitle H. Excise taxes on insured and self-insured health plans

Present Law.—There is no excise tax or other special Federal tax on domestic health insurance policy premiums. A one-percent excise tax is imposed on premiums for certain foreign-issued sickness and accident insurance and reinsurance policies (sec. 4371).

Explanation of Provision.—The bill would impose an excise tax on accident or health coverage provided (whether through insurance policies or otherwise) with respect to residents of the United

States,⁴⁷ as well as on certain related administrative services. No excise tax would be imposed on accident or health coverage if substantially all of the coverage relates to liabilities incurred under workers' compensation laws, tort liabilities, liabilities relating to ownership or use of property, credit insurance, or such other similar liabilities as may be specified by the Secretary of Treasury in regulations. Accident or health coverage would include, but would not be limited to, coverage for sickness, accident, dental, preventive care, payments as a result of a medical condition, or payment of a fixed amount for specific diseases or hospitalization or other specific types of care.

In general, with respect to health insurance, the tax would be imposed on premiums. With respect to prepaid health care arrangements, the tax would be imposed on the fixed payments or premiums paid by members. With respect to self-insured plans, the tax would be imposed on the accident and health coverage expenditures and the administrative expenses of the plan.

Amounts derived from the imposition of the excise tax would be used to fund four accounts in the Health-Related Programs Trust Fund created under section 11911 of the bill.

Tax on accident and health insurance policy premiums

The bill would impose a 2-percent excise tax on the premium for any policy providing accident or health coverage. The issuer of the policy would be liable for the tax. The tax would be imposed regardless of who pays the premium.

If a policy subject to the tax provides both accident or health coverage and non-accident or health coverage, no tax would be imposed on the portion of the premium attributable to the non-accident or health coverage if the charge for such other coverage is separately stated or furnished to the policyholder in a separate statement, and is reasonable in relation to the total charges under the policy.

Arrangements under which (1) a person receives fixed payments or premiums in exchange for an agreement to provide or arrange for the provision of accident or health coverage, and (2) substantially all of the risk of utilization of health care services is assumed by such person or the provider of such services (i.e., prepaid health care arrangements) would be treated as insurance policies subject to the tax. In such a case, the tax would be imposed on such payments or premiums. The person receiving the payments or premiums would be treated as the issuer of the policy and would be liable for the tax.

Tax on health-related administrative services

The bill also would impose a 2-percent excise tax on amounts paid for certain health-related administrative services not included in the premium for a policy. The tax would be imposed on the provider of the services.

Services subject to the tax would include claims processing or other administrative services performed in connection with acci-

⁴⁷ The bill would generally define the "United States" to include possessions of the United States.

dent or health coverage (if the charge for such services is not included in the premiums for such policy), and claims processing, arranging for the provision of accident or health coverage, or other administrative services performed in connection with a self-insured plan established or maintained by another person.

Treatment of self-insured plans

Self-insured plans would be subject to a monthly tax equal to 2-percent of the sum of the plan's expenditures for accident and health coverage (as defined above) and direct administrative expenses for the month. The tax would be paid by the plan sponsor.

Plans subject to the tax would be plans that provide any accident or health coverage other than through an insurance policy, and that are established or maintained by (1) one or more employers for the benefit of their current or former employees; (2) one or more employee organizations for the benefit of their current or former members; (3) one or more employers and employee organizations jointly for the benefit of current or former employees; (4) a voluntary employees' beneficiary association described in Code section 501(c)(9); (5) any organization discussed in Code section 501(c)(6); and (6) a multiple employer welfare arrangement or plan maintained by rural electric cooperatives or by rural telephone cooperative association, not described in (1)–(4) above.

The accident and health coverage expenditures of a plan for any month would not include expenditures subject to the excise tax on accident and health insurance policy premiums or expenditures subject to the excise tax on health-related administrative services, described above. In addition, any reimbursements received by the plan sponsor (through insurance or otherwise) would be subtracted from accident and health coverage expenditures.

Depreciation expenses allowable under Code section 167 would be treated as accident and health coverage expenditures. Accident and health coverage expenditures would not include any other expenditure for the acquisition or improvement of land or for the acquisition or improvement of any property to be used in connection with the provision of accident or health coverage which is subject to depreciation allowance.

The following examples illustrate the operation of the tax with respect to self-insured plans.

Example 1.—Employer A maintains a self-insured plan and has a contract with Insurance Company X to provide administrative services only with respect to the plan. Employer A is liable for the excise tax with respect to accident and health coverage expenditures under the plan. Insurance Company X is liable for the tax with respect to amounts received from Employer A for administrative services.

Example 2.—Employer B maintains a plan that is self-insured, and purchases stop-loss coverage from Insurance Company Y. Employer B is liable for the excise tax with respect to accident and health coverage expenditures under the plan. In applying the tax, the amount of any reimbursements received from Insurance Company Y under the stop-loss policy are subtracted from total accident and health coverage expenditures. Insurance Company Y is liable

for the tax with respect to the premiums paid for the stop-loss policy by Employer B.

Exemption applicable to certain governmental programs

Certain direct governmental insurance programs would be exempt from the excise tax. Exempt governmental programs would be Medicare Parts A and B, Medicare Part C, Medicaid, any program that provides health coverage (other than through an insurance policy) to members of the Armed Forces or veterans or to their spouses or dependents, and any program established by Federal law for providing medical care (other than through an insurance policy) to members of Indian tribes. Other government programs would be subject to the excise tax.

Revenues dedicated to Health-Related Programs Trust Fund

Portions of the net revenues collected from the excise tax would be dedicated to four different accounts in the Health-Related Programs Trust Fund created under section 11911 of the bill. The Health Care Workforce Account would receive amounts equivalent to 50 percent of the net revenues derived from the excise tax; the Biomedical Research Program Account would receive amounts equivalent to 25 percent of the net revenues derived from the excise tax; the Undergraduate Medical Education Program Account would receive \$50 million per fiscal year; and the Lead Paint Abatement Program Account would receive \$500 million per fiscal year.

Effective Date.—The excise tax would be effective for payments and premiums received and expenses incurred after December 31, 1995.

Subtitle I. Other provisions

Sec. 12. Nonrefundable Credit for Certain Primary Health Services Providers

Present Law.—

Geographically targeted tax provisions

In general, the operation of Internal Revenue Code rules does not vary based on the location within the United States of income-producing activity. Nonetheless, present law provides favorable Federal income tax treatment for certain U.S. corporations that operate in Puerto Rico, the U.S. Virgin Islands, or possessions of the United States to encourage the conduct of trades or business within these areas. In addition, certain Code sections provide additional benefits in targeted geographic areas (e.g., low-income housing credit and qualified mortgage bond provisions target certain economically distressed areas).

The Omnibus Budget Reconciliation Act of 1993 ("1993 Act") provides for the designation of nine empowerment zones and 95 enterprise communities in economically distressed areas satisfying certain criteria. The designations are to be made during 1994 and 1995, and generally will remain in effect for 10 years. During the period the designation is in effect, special tax incentives (i.e., an employer wage credit, additional section 179 expensing, and ex-

panded tax-exempt financing) are available for certain business activities conducted in empowerment zones. Expanded tax-exempt financing benefits are available for certain facilities located in enterprise communities. In addition, the 1993 Act provides accelerated depreciation benefits and an incremental employer wage credit for certain business activities conducted on Indian reservations.

Tax benefits available for medical care providers

Code section 108(f) provides an exclusion from Federal income tax for what otherwise would be discharge-of-indebtedness income if a student loan is discharged pursuant to a provision in the loan agreement that requires the student to work for a period of time in certain professions for any of a broad class of employers. Section 108(f) applies only to student loans made from funds provided by the Federal Government, a State or local government, or certain public benefit corporations described in section 501(c)(3). For example, the favorable treatment provided by section 108(f) applies when a government agency discharges a student loan upon the student's provision of medical services to an underserved area.

Present law does not provide for a special credit against Federal income taxes for individuals who provide medical services in medically underserved geographic areas.

Non-tax benefits for medical care providers

Other, non-tax provisions of Federal law provide that certain health care professionals who agree to work full time for at least two years at an approved government or nonprofit employment site within a "health professional shortage area" (HPSA) are eligible for scholarships or repayments of student loans.⁴⁸ The scholarship and loan repayment programs are administered by the National Health Service Corp (NHSC), which is part of the Department of Health and Human Services.⁴⁹

Explanation of Provision.—A physician who provides primary health services in certain medically underserved areas would be eligible for a nonrefundable credit against Federal income taxes of \$1,000 per month for up to 60 months. The credit rate would be \$500 per month in the case of a physician assistant, nurse-practitioner, or certified nurse-midwife. The credit would be available to a taxpayer only if he or she provides primary health services⁵⁰ on

⁴⁸ HPSAs are designated geographic areas, as well as certain designated population groups and government facilities. Currently, more than 2,400 primary care HPSAs have been designated, covering all or parts of 1,800 counties in the United States. There are also over 1000 dental HPSAs and over 700 mental health HPSAs. HPSAs are designated by the Bureau of Primary Health Care, which is part of the United States Public Health Service. HPSAs are identified on the basis of State and local government requests for designation. Primary care HPSAs are designated on the basis of rate of poverty, access to primary health care, low birthweight births, infant mortality, and the physician/population ratio. See vol. 59 *Federal Register* no. 14 (January 21, 1994) at 3411-5307. The NHSC Revitalization Amendments of 1990 (sec. 333A of Pub. Law 101-697) require that the Secretary of HHS annually prepare a list of HPSAs in order of greatest shortage of medical practitioners (by using certain exclusive factors and that priority in the assignment of National Health Service Corp (NHSC) personnel be given to government or nonprofit entities serving HPSAs with the greatest shortages. See 42 U.S.C. 254f-1.

⁴⁹ As of September 30, 1993, a total of 1,163 practitioners (i.e., primary-care physicians and physician assistants, general practice dentists, primary-care nurse practitioners, and certified nurse midwives) were providing medical care in HPSAs throughout the United States pursuant to the NHSC scholarship and loan repayment programs.

⁵⁰ For purposes of the provision, the term "primary health services" would have the meaning given such term by section 330(b)(1) of the Public Health Service Act.

a full-time basis in a "health professional shortage area" (HPSA) (as defined under present-law section 332(a)(1)(A) of the Public Health Service Act).⁵¹ To be eligible for the credit, the taxpayer would be required to obtain certification, at the time of commencement of work in the area, from the Bureau of Primary Health Care, United States Public Health Service of the Department of Health and Human Services, that he or she is a full-time provider of primary health services in a HPSA. Thus, the credit would not be available to a taxpayer who already is providing primary health services in a HPSA at the time the credit becomes effective. In addition, the credit would not be available if the taxpayer participated in the National Health Service Corps (NHSC) scholarship or loan repayment program. The credit would not be allowed as an offset against alternative minimum tax (AMT) liability (Code sec. 26).

Under the provision, a taxpayer would be required to work full time providing primary health services in a HPSA for five consecutive years in order to receive the tax credit. If a taxpayer did not provide primary health services on a full-time basis in a HPSA for at least two consecutive years, no credit would be allowed and any credit previously claimed would be completely recaptured. A portion of the credit would be available if the taxpayer provided primary health services on a full-time basis in a HPSA for more than two consecutive years; the remaining portion of any credit previously claimed would be recaptured.⁵² The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, would be granted authority to waive recapture of credits when a taxpayer ceases to provide services in the HPSA due to extraordinary circumstances.

Effective Date.—The provision would be effective for taxable years beginning after 1994.

Sec. 13. Expensing of Medical Equipment

Present Law.—

Depreciation rules

In general, the cost of property that has a useful life longer than one year must be capitalized and recovered over time pursuant to depreciation or amortization rules. Tangible depreciable property placed in service after 1986 is depreciated under the modified Accelerated Cost Recovery System (MACRS) enacted as part of the Tax Reform Act of 1986. Under MACRS, high technology medical equipment is depreciated for regular tax purposes over a 5-year recovery period using the 200-percent declining balance method.

⁵¹ See Title 42, U.S. Code, sections 254e. For purposes of the credit, a health care professional would be treated as providing services in a HPSA, even if the area (or population group) no longer has designation as such, so long as the area (or population group) was a HPSA when the professional began providing services in such area (or to such population group).

⁵² If a taxpayer ceases performing primary care services in a HPSA during his or her third year of service, then no credit would be allowed for that year and 75 percent of all credits from the two preceding years would be recaptured. If a taxpayer ceases performing primary care services in a HPSA during his or her fourth year of service, then no credit would be allowed for that year and 50 percent of all credits from the three preceding years would be recaptured. If a taxpayer ceases performing primary care services in a HPSA during his or her fifth year of service, then no credit would be allowed for that year and 25 percent of all credits from the four preceding years would be recaptured.

"High technology medical equipment" means any electronic, electromechanical, or computer-based high technology equipment used in the screening, monitoring, observation, diagnosis, or treatment of patients in a laboratory, medical, or hospital environment.

In general, the benefits of the accelerated MACRS deductions are reduced for property under an alternative depreciation system that applies to foreign use property, tax-exempt use property, tax-exempt bond financed property, certain imported property, and property which the taxpayer so elects. The alternative depreciation system also is used to compute corporate earnings and profits. The benefits are reduced by calculating depreciation using the straight-line method over the property's class life. A property's class life generally corresponds to its Asset Depreciation Range (ADR) midpoint life and often is longer than the recovery period applicable for regular tax purposes. The class lives of the alternative depreciation system also are used for purposes of the corporate and individual alternative minimum tax. The class lives of some assets are set by statute, regardless of the asset's ADR midpoint life. The class life of high technology medical equipment is set by statute at five years.

Section 179 expensing allowances

In lieu of depreciation, a taxpayer with a sufficiently small amount of annual investment may elect to deduct immediately up to \$17,500 of the cost of qualifying property placed in service for the taxable year under section 179.⁵³ In general, qualifying property is defined as depreciable tangible personal property that is purchased for use in the active conduct of a trade or business. The \$17,500 amount is reduced (but not below zero) by the amount by which the cost of qualifying property placed in service during the taxable year exceeds \$200,000. In addition, the amount eligible to be expensed for a taxable year may not exceed the taxable income of the taxpayer for the year that is derived from the active conduct of a trade or business. Any amount that is not allowed as a deduction because of the taxable income limitation may be carried forward to succeeding taxable years (subject to similar limitations).

Explanation of Provision.—The provision would increase the amount allowed to be expensed under section 179 in a taxable year by the lesser of: (1) the cost of section 179 property which is health care property placed in service during the year or (2) \$10,000. For this purpose, "health care property" would mean section 179 property: (1) which is medical equipment used in the screening, monitoring, observation, diagnosis, or treatment of patients in a laboratory, medical, or hospital environment; (2) which is owned (directly or indirectly) and used by a physician (as defined by section 1861(r) of the Social Security Act) in the active conduct of such physician's full-time trade or business of providing primary health services (as defined in section 330(b)(1) of the Public Health Service Act) in a health professional shortage area ("HPSA") (as defined in section 332(a)(1)(A) of the Public Health Service Act); and (3) substantially all the use of which is in such area.

⁵³ Section 1397A of the Code increases the amount allowed to be expensed under section 179 by an enterprise zone business by the lesser of: (1) \$20,000 or (2) the cost of section 179 property that is qualified zone property placed in service during the taxable year.

As provided in (2) above, a taxpayer must satisfy both an ownership and a use test in order to be eligible for the additional expensing provided by the bill. First, the property must be owned (directly or indirectly) by a physician. For this purpose, indirect ownership would include ownership by an entity in which substantially all the ownership interests are held by physicians. Second, the property must be used in the active conduct of a physician's full-time trade or business of providing primary health services in a HPSA. For this purpose, "use" would mean more than a de minimis amount of use and would not include the equipment as a lessor.⁵⁴ In addition, in the case of multiple or indirect ownership, substantially all the owners must use the property. Thus, for example, property owned by a partnership that has two physicians as equal partners would not qualify for the additional expensing unless both partners use the property in the active conduct of their full-time trades or businesses of providing primary health services in a HPSA for more than a de minimis amount of use.

As under present-law section 179, benefits provided by the provision with respect to any property that ceases to be health care property would be recaptured.

Effective Date.—The provision would apply to property placed in service in taxable years beginning after December 31, 1994.

Sec. 14. Health-Related Programs Trust Fund

Present Law.—No provision.

Explanation of Provision.—The bill would establish a Health-Related Programs Trust Fund in the Internal Revenue Code, which would consist of four Accounts. All of these Accounts would be funded from revenues derived from the excise taxes imposed on insured and self-insured health plans set forth in section 11801 of the bill and described above (see Subtitle H).

The Lead Paint Abatement Program Account would receive \$500 million per fiscal year. Amounts from this Account would be available to fund the Lead Paint Abatement Program described in Title VII(D) of the bill. The Biomedical Research Program Account would receive amounts equivalent to 25 percent of the net revenues derived from the excise taxes.⁵⁵ Amounts from this Account would be available to fund the Biomedical Research Program described in Title VII(E) of the bill. The Health Care Workforce Account would receive amounts equivalent to 50 percent of the net revenues derived from the excise taxes. Amounts from this Account would be available to fund the Health Care Workforce Program described in Title VII(A) of the bill. The Undergraduate Medical Education Program Account would receive \$50 million per fiscal year. Amounts in this Account would be available to fund the Undergraduate Medical Education Program described in Title VII(B) of the bill.

Effective Date.—The provision would be effective on the date of enactment.

⁵⁴ Property that is both used in the active conduct of a physician's full-time trade or business of providing primary health care services in a HPSA and leased may qualify for the additional expensing if there is sufficient use of the property in the active conduct of the physician's trade or business.

⁵⁵ Net revenues from the excise taxes on health plans would be the gross amount received in the Treasury from the excise taxes less amounts attributable to the income tax offset due to the imposition of the excise taxes.

IV. BUDGET EFFECTS OF THE BILL

1. CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

The Committee has not received an estimate of the amendment from the Director of the Congressional Budget Office. The Committee intends to comply with clause 2(1)(3)(C) of rule XI of the Rules of the House of Representatives by providing a cost estimate prepared by the Congressional Budget Office in a supplemental report, as soon as such an estimate is provided by the Director.

2. STATEMENT REGARDING NEW BUDGET AUTHORITY AND TAX EXPENDITURES

The amendment contains both new budget authority and tax expenditures. However, the Committee has not received an estimate of the amendment from the Director of the Congressional Budget Office. The Committee intends to comply with clause 2(1)(3)(B) of rule XI of the Rules of the House of Representatives by providing a statement regarding new budget authority and tax expenditures in a supplemental report, as soon as such an estimate is provided by the Director.

3. COMMITTEE ESTIMATE

The Committee has not prepared an estimate of the amendment.

V. OTHER MATTERS REQUIRED TO BE DISCUSSED UNDER THE RULES OF THE HOUSE

1. VOTE OF THE COMMITTEE

In compliance with clause 2(1)(2)(B) of rule XI of the Rules of the House of Representatives, the following statement is made: the bill, H.R. 3600 was ordered favorably reported with an amendment to the House of Representatives on June 30, 1994, by recorded vote, 20 to 18.

2. OVERSIGHT FINDINGS

In compliance with clause 2(1)(3)(A) of rule XI of the Rules of the House of Representatives, the Committee reports that the need for this legislation was confirmed by the oversight hearings of the Subcommittee on Health.

The Subcommittee conducted a total of 33 days of hearings of which 14 days were on topics related to health reform generally, and 19 days were on the President's proposal and competing alternatives. Among the topics covered during the hearings were issues relating to cost containment, insurance reform, administrative simplification, graduate medical education, impact of the proposal on low-income populations, national anti-fraud and abuse efforts, physician self-referral, managed care, health benefits, and related topics.

3. OVERSIGHT BY COMMITTEE ON GOVERNMENT OPERATIONS

In compliance with clause 2(1)(3)(D) of rule XI of the Rules of the House of Representatives, the Committee states that no oversight findings and recommendations have been submitted to the Com-

mittee on Government Operations with respect to the subject matter contained in this bill.

4. INFLATION IMPACT

In compliance with clause 2(1)(4) of rule XI of the Rules of the House of Representatives, with regard to the inflationary impact of the reported bill, the Committee believes that the bill will reduce the rate of growth in health care prices, and will, over time, reduce the rate of growth in consumer prices generally.

5. FEDERAL ADVISORY COMMITTEE ACT

In accordance with section 5(b) of the Federal Advisory Committee Act, the bill as reported establishes the following advisory committees:

- National Health Advisory Commission
- Advisory Commission on Mental Health and Substance Abuse
- National Health Cost Commission
- U.S.-Mexico Border Health Commission
- Prescription Drug Payment Review Commission
- Health Care Quality Advisory Commission

VI. CHANGES IN EXISTING LAW MADE BY THE BILL AS REPORTED

In the opinion of the Committee, in order to expedite the business of the House of Representatives, it is necessary to dispense with the requirements of clause S of rule XIII of the Rules of the House of Representatives (relating to showing changes in existing law made by the bill as reported).

VII. ADDITIONAL, MINORITY, AND SUPPLEMENTAL VIEWS

ADDITIONAL VIEWS SUBMITTED BY MR. ANDREWS

I would like to express my concern regarding the provision in the Ways and Means Committee's legislation in Title V. related to an amendment offered by Mr. Jefferson dealing with any willing providers. The language in the legislation and in the report is vague. Yet, there was extensive discussion around the amendment in which the members of the Committee clarified the intent of the amendment.

During the debate, in trying to establish whether or not a health plan would be required to hire unlimited providers, I posed a hypothetical situation. If a health plan determined that it could provide adequate quality of and access to service by hiring a certain number of a certain type of provider, a health plan could hire that number of providers. Specifically, I asked whether a health plan with 12 providers that decided it only needed 10 to provide adequate access could eliminate two providers. Mr. Jefferson definitively answered that his amendment would not prevent a health plan from doing so.

In addition, I asked whether a health plan that determined that certain providers were less efficient than others could eliminate those providers. Again, Mr. Jefferson responded that his amendment would not prevent a plan from doing so, and that such a decision would fall under the portion of his amendment which allows a health plan to "establish any other measure designed to maintain quality and to control costs". Mr. Jefferson's answers were clear and unambiguous.

Further, I understand the amendment intends that providers cannot be denied an opportunity to participate in a health plan provided that the health plan is not limited from implementing any requirements and procedures necessary to deliver cost effective high quality health care. Further, this provision does not limit the health plan's ability to determine that all providers meet its qualifications. The providers must be willing to accept all of the plan's terms and conditions, including: the schedule of fees or other compensation arrangements developed by the health plan; covered expenses, including agreement to collect no more from enrollees in out-of-pocket charges than specified in the coverage selected by the enrollee; and quality standards, including participation in the health plan's quality improvement program, collection of all data requested by the health plan, and compliance with all other aspects of the plan's quality assessment and improvement system. All providers participating in a health plan must comply with an health plan program instituted to meet the above described requirements.

Health plan requirements related to the ability of the plan to deliver cost effective, high quality health care may include use of credentialing criteria and negotiation of fee discounts and other compensation arrangements. These requirements may also include matching the availability of health care providers to the needs of the enrollees of the plan to ensure that the capacity to provide covered services matches the anticipated needs of the health plan's enrollees. This would include allowing the plan to determine the complement of providers in the plan based on the characteristics, geographic distribution and anticipated health care needs and other factors affecting delivery of care to enrollees.

This provision is not intended to limit or interfere with the fundamental operating structure of a health plan. Health plans retain the flexibility to implement measures such as those defined above and others as needed to maintain quality and control costs. Plans would retain the discretion to determine the appropriate mix of specialist and other types of providers necessary to deliver all covered services and nothing in this provision would require that particular types or categories of providers must be available to provide specific types of services. This provision would not limit a plan's ability to choose the providers best suited to providing care in an integrated delivery system or the ability of a plan to determine staffing needs for primary care physicians, specialists and other providers that are appropriate to the enrolled population served in particular geographic areas. All providers must participate in plan activities necessary to collect data and submit standardized reports which allow for the development of comparative information to assist consumers in making an informed choice among health benefits options.

Dedicated group and staff model HMOs are exempted from this provision. This exemption recognizes that physicians and other providers participating in these HMO models serve the enrollees on a full-time basis in facilities dedicated to providing care via integrated systems of health care delivery.

MINORITY VIEWS

President Clinton has said he wants to “end welfare as we know it”—but the Ways and Means Committee’s version of H.R. 3600 will help him “end health care as we know it” first. Clearly that is what the President’s original health plan envisioned. He simply had not described it that way.

We cannot remember when the Ways and Means Committee has embarked on a greater—or riskier—social experiment than that embodied in the committee reported health care bill. In this regard particularly, the majority followed the Clinton Administration’s agenda to restructure the entire U.S. health care system to a degree far beyond the needs or wants of the American people.

The committee should have taken a different approach, a more rational approach that would improve—not end—health care as we know it. Unfortunately, the majority listened to White House social engineers instead of the American people who have repeatedly told us that they do not want to be the guinea pigs in some Washington bureaucrat’s political laboratory.

If the committee’s majority had listened to the people, they would have heard an appeal for insurance reforms, portability of coverage, premium subsidies for low income families, continuation of high quality medicine, the freedom to choose your own doctor, and flexibility for states and the marketplace to try new ideas. Most of all they would have heard a plea to forgo complex and radical changes to our health care financing and delivery system, a plea to proceed slowly and carefully with full knowledge about the costs and the effects on the lives it would touch, and a plea to fix only that which needs to be fixed.

Much in our current system is working just fine. The marketplace is already reducing the growth of private sector health expenditures, and the vast majority of the American people are happy indeed with the health care they are receiving. For them, this bill’s approach means less health care—not more; lower quality care—not better; rationing—not ready availability. For many, it will mean loss of a job, or a cut in pay.

ENDING HEALTH CARE AS WE KNOW IT

But rather than thoughtfully improving our health care system, the committee chose to end health care as we know it by scrapping the finest health care system in the world and replacing it with a government run program based on unproven academic theory.

More than half of the American people will be in government run health care programs under the Clinton/Ways and Means bill, and for those who are not, there is still no escape. The federal government also will regulate and micro-manage everything in the private market—the benefit package, the payments to providers, the number and kinds of doctors trained and the amount and type of insur-

ance you can buy to supplement your coverage. The bill also sets up a computer data system to keep track of every time someone uses the system and how much their treatment costs. Doctors and hospitals would be required to report an individual's clinical data into the computer system as well. Doctors, hospitals, federal bureaucrats, quality experts, and researchers will be able to access this federal central health care data base.

MORE GOVERNMENT, LESS CHOICE

The committee bill represents everything the American public dislikes about Washington. It is just more of the same old thing. The same big lumbering and intrusive government, financed by increased taxes, will be delivering "one size fits all" health care without regard for local needs or the ability to respond quickly to technological changes or the changing needs of a modern nation.

Only if you believe that the federal government will control social program costs and provide services in a timely, efficient and hassle-free fashion can you believe in the success of the new totally unnecessary federal Medicare Part C program and federal government regulation of private health insurance and health providers.

We have yet to hear the Administration's views on the bill. We have not even heard from our own Congressional health care advisory commissions on many of its provisions. In fact, since many of the bill's policies were never subject to the normal hearing process, we have not heard the views of many of the affected individuals, consumer groups, state governments or businesses on important provisions it contains—particularly issues relating to increased costs and unfunded mandates. Full hearings on the specific policies should be a fundamental step before the bill proceeds further.

FINANCING SCHEME QUESTIONABLE

For its financing, the Clinton-Ways and Means Committee bill relies upon mandated employer payments (a portion of which are retained by the Treasury and never spent for employee coverage), excise taxes on health care, additional taxes on tobacco products, global health care budgeting, federal health care wage and price controls, and huge cuts in Medicare and Medicaid.

In reality, the committee bill, like the original Clinton bill, raises more in taxes and makes more cuts in spending than is needed to provide basic insurance coverage for the uninsured. Much of the money is being used for new spending and benefits outside of the stated purpose of the bill—universal health care coverage for all Americans.

This is particularly true of the Medicare cuts which dwarf any reductions previously proposed in the program. While some of the savings from the cuts will go back to the elderly in the form of a new entitlement such as a drug benefit and some small assistance with home-based care for the disabled, the fact is that the elderly population is paying for a large chunk of someone else's agenda.

Quite disturbing is the almost certain knowledge that the financial estimates for this bill are not accurate and may be off by billions of dollars. For a frightening number of the items in the bill, basic underlying data are simply not available. Hundreds of the bill's provisions will result in some sort of behavioral change. Even

viewed in isolation, many of these changes are unpredictable. Most changes will interact with one another and bring about new unanticipated problems. The degree of confidence the estimators have in predicting the budgetary consequences of a bill as complex as this one is far less than what we have grown accustomed to in the budget reconciliation process—and yet many more billions of dollars are at stake. Not only is this the largest and most expensive governmental social engineering experiment in our history, it is also the piece of legislation that we know the least about in terms of predicting costs, revenues, behavioral and interactive effects and—most importantly for the well-being of our citizens—harmful unintended consequences.

Behavioral change resulting from the radical elements of the committee's bill is certain to be very volatile—unlike today where changes in behavior occur, but far more predictably due to the more predictably due to the more constructive pace of reform in the current marketplace. The unpredictability of changes forces by this legislation could increase the cost of the committee's bill by hundreds of billions of dollars.

According to the Congressional Budget Office, the overall bill is underfinanced. The administrative costs add to the deficit projections. Many of the costs of running the committee proposal will fall to the appropriating committees who will soon see it squeeze out other domestic programs in the budget as the administrative costs eat up almost six percent of the appropriations spending cap.

Besides the great risk that the Clinton-Ways and Means bill will lower the quality of health care for the vast majority of Americans who are now satisfied with their care, we cannot overlook the fact that this bill would represent the largest tax increase in our nation's history—breaking the record set just last year by President Clinton's 1993 tax bill—and these taxes are anti-consumer and anti-employee.

THE EMPLOYER MANDATE AND OTHER TAXES

The primary tax in this bill is the so-called “employer mandate.” Employers would be required to pay 80% (more in some cases) of the health care premiums for their employees. For two-worker families, both employers would be required to pay health insurance premiums (or their equivalent). A complicated tax credit system is supposed to help offset the costs of the employer providing the larger family premium. But thanks to a provision described candidly as “skimming” by one of its Democrat authors, the government would collect and keep as much as 75% of the money paid by the non-insuring employer, rather than pass it on to the employer providing the family coverage.

The employer mandate is simply bad public policy. It imposes a tremendous additional burden on the nation's employers, particularly small businesses which account for much of our needed job growth. The temporary nature of the bill's small business subsidies renders them virtually useless in protecting American jobs. According to a new study by the respected CONSAD Research Corporation, the employer mandate will affect some 50 million American jobs in one way or another—and will result in a net loss of approximately 1 million jobs.

The insurance mandates would also impose massive direct taxes on individuals, enforced through the Internal Revenue Code. Virtually everyone (except conscientious objectors and prisoners) would be required to have health insurance. Employees would be required to pay any share of insurance costs not imposed on their employer. Those who are self-employed or unemployed would be required to pay the full premium (with no additional tax deduction for unemployed individuals and only a partial deduction for the self-employed). All of this tax would be reconciled every year on the individual's Form 1040. How many millions of hours will this add to the nation's cumulative tax paperwork burden—and at what cost?

The bill singles out tobacco products for huge excise tax increases. Since the majority was in a taxing mood, that begs the question why, if health concerns are to be the justification for the increase on tobacco, the bill does not also impose or increase excise taxes on other products that may be hazardous to health. There is also questionable fiscal logic in funding the health bill into perpetuity with a revenue stream from a tax on a product the Administration is seeking virtually to eliminate.

The bill also imposes taxes on health care itself—through a 2% tax on health insurance premiums and a 2% tax on the aggregate health care expenditures and direct administrative expenses of self-insured plans. How will a tax on insurance premiums and self-insured plans promote the bill's supposed overriding goal of making health insurance more affordable? It will not. In fact, this tax will have the opposite result.

Other taxes that will provoke questions among the American people are the elimination of health benefits in "cafeteria plans" for employees, the imposition of medicare taxes on all state and local governments and their employees, new taxes and penalties on tax-exempt health care organizations and their employees, new penalties for tax filings on service providers, and limits on deducting pre-funded health premiums and retiree health benefits.

GOVERNMENT TO DICTATE EVERYONE'S HEALTH BENEFITS

Over 120 million Americans who are low income, elderly, unemployed, or who work for small business employing under 100 people will be in Medicare. Meanwhile, the rest of the nation will have their health benefits dictated to them by the U.S. Congress and regulated by federal bureaucrats in Washington.

Medicare provides an excellent example why a statutorily-defined benefit package is a bad idea. The current Medicare benefit package is out of date—despite constant Congressional efforts to tinker with it. The program relies heavily on price controls which have limited the availability of care and exacerbated shifting of cost to non-Medicare patients. Medicare enrollees have a limited choice of benefits. They only have two ways to enhance their benefits: purchase of private Medigap coverage and joining a Medicare risk-contract program. Even Medigap coverage, however, is limited in the amount of additional benefits it can offer. The creation of Medigap (the "wrap-around" market), resulted in higher utilization, higher costs, and greater risk selection.

Even with that history, the bill's authors want to follow the same model. Everyone will have to buy a standard set of benefits (the new Medicare benefit package) whether they need all of those benefits or not. Of course, updating or adding any additional benefits to the Medicare package, to which all private benefits will be linked, will depend on whether Congress decides to increase Medicare benefits and pay for them. That means your access to the latest in modern medicine will not be up to you or your employer, but will have to wait literally for the proverbial "Act of Congress."

Many of the benefits in the Medicare program, and particularly the cost sharing scheme, reflect those of the insurance system of the 1960's. They have not kept up with modern medicine. Why should we expect this new program to be any different?

Today's Medicare program is fiscally unsound, and the committee's bill significantly expands the program without addressing the underlying structural problems. The reimbursement levels of Medicare have reached potentially disastrous levels, as ProPAC's current report underscores.

Anyone who doubts this only has to look at the current Medicare program for the elderly and the Medicaid program for the poor. For more than a decade, Congress has cut back on payments to doctors and hospitals until they no longer cover the cost of care for Medicare and Medicaid patients—and the additional massive cuts in reimbursement to providers proposed in this bill will reduce the quality of care for the nation's elderly. There will be no place else to shift those costs any longer.

GOVERNMENT WAGE AND PRICE CONTROLS—A PRESCRIPTION FOR RATIONING

The bill's radical "cost containment" provisions involve the use of "global budgeting" through national spending targets which in turn are broken down into state by state spending limits. The committee bill's goal is to bring the rates of increase in health care spending down to levels that no industrialized nation with a modern health care system has achieved in recent years.

For example, according to the most recent data from the Organization of Economic Cooperation and Development (OECD) for the years 1985–1991, Canadian health care expenditures grew annually at a rate of 4.8% above inflation and the British nationalized system grew annually at 4.1% above inflation. These countries have not been able to contain health care costs even with global budgets, governmental price fixing and severe controls on technology. They have not been able to reduce their health care cost growth rates despite draconian measures such as denying and limiting health care services, closing hospitals for all but emergency care for periods of time, severely curtailing specialist services, delivering inferior services, and making access difficult through long waiting lines.

In spite of that evidence, the Clinton-Ways and Means Committee bill sets up a huge, unworkable bureaucracy with powers to regulate the entire health care system—one seventh of the nation's economy. The committee has struggled for years in setting prices for hospitals and doctors for Medicare services—often with devastating and unfair results for entire sections of the health care in-

dustry and whole segments of the Medicare population. As a result, Congress has been deluged continually with demands for policy and technical fixes to correct harmful consequences of prior years' legislation. Congressional wage and price setting has reduced access to health care for millions of poor Medicaid beneficiaries—leaving them with “on paper only” benefits.

Now, in a real life fulfillment of a bureaucrat's wildest dream, Washington would impose on all health expenditures an incredibly complex scheme of global budgets and spending targets, state expenditure limits and expenditure limits for at least ten classes of specific health care services. To enforce this unworkable structure, the committee exhumed an ancient idea with a perfect track record of failure—government price controls.

Rationing health care by limiting access to benefits, while at the same time promising more, is the cruel outcome the White House and the committee would like to deny but cannot. National expenditure limits are to be translated to the state level without regard for future health trends the state may experience. If a state exceeds its target limit, government price controls using the Medicare price setting methodology will apply to all private health care plans. Those under Medicare Part C will always be subject to these controls regardless of the targets. States and providers do not have even the right to due process—the right of review and appeal on the expenditure allocations, the methodology used to set prices, or the adequacy of the prices themselves.

Anyone who has lived with a price control system knows that you generally get less of the item being controlled, and often with a reduction in quality. Medicine is no different, and the cost containment schemes tried by other nations have resulted in forced unpaid “doctor's holidays,” denial of benefits to the aged, providing benefits for certain services only to those who “deserve” the procedure, long waiting lines for serious and chronic ailments, or longer distances to travel to obtain life saving treatments.

In addition to rationing care, allocation of expenditures by classes of health care services and technology will freeze in place the current practices and technology plus the inefficiencies of today's medicine. For example, all spending on drugs will have an expenditure limit in each state.

Suppose a drug is found to cure breast cancer, thereby providing not only a cure, but the end of surgery and its tremendous expense. Overall the quality of life would improve, and the cost of treatment could drop, but because there is a limit on drug expenditures, the use of the drug would be limited or it would squeeze out the use of other drugs for other diseases. Moreover, the Congressional Budget Office recognizes that the policies in the Clinton-Ways and Means bill will steer drug research and development dollars away from the diseases affecting the elderly (such as Alzheimer's) and toward the under-65 population. The Ways and Means Committee's cost controls could dash the hopes of many who are anticipating “the cure of the future.” Traditionally physicians take the Hippocratic oath when they graduate from medical school. The essence of the oath is “to do no harm” in practice. Unfortunately, the Clinton-Ways and Means Committee bill doesn't meet this standard.

The committee bill is totally silent on one of the chief ways of providing health care more effectively—changing the nation's anti-trust laws to allow providers, insurers and local governments to combine their resources more efficiently to reduce cost and improve health care services.

In addition, with the exception of a nod to managed care, the bill does not address any of the cost growth factors on the delivery side of the equation. Regrettably, the committee refused to include in its bill a significant tool that many states are turning to in an effort to deal with rising health care costs—strong malpractice reforms. If left unchecked, the cost of defensive medicine and rising malpractice insurance rates will continue to grow.

State and local governments have been the innovators in bringing costs under control for public programs by creating unique health systems to serve their community needs. The bill's cost controls would provide a straitjacket instead of freedom to explore more efficient alternatives. For those employed in the health field, the bill's wage and price controls will make providers the servants of the federal government and not the patient.

In fact the greatest failing of the committee's purported cost control system is that it really does not directly attack the basic cost-drivers themselves. Their approach is much more akin to attempting to stop a boiling pot of water from overflowing by clamping down a lid on it—rather than turning down the underlying heat itself.

GOVERNMENT RUN HEALTH CARE SYSTEM—ARE WE READY FOR IT?

Within the first six titles of the Chairman's 10th bill, there are more than 160 new Federal responsibilities allocated to either the Secretary of Health and Human Services or the Secretary of the Treasury. Aside from the major health policy issues, there are numerous unanswered questions regarding the administration, regulation, oversight and enforcement provisions in the committee bill. For example, the bill gives the Secretary of Health and Human Services well over 100 new regulatory responsibilities—even though the committee has yet to hear from the Secretary of Health and Human Services whether she has adequate resources to put in place the administrative and regulatory structures required to carry out these new responsibilities.

Nor has the committee heard from the Secretary of Health and Human Services whether she will be able to develop rules, enforcement procedures and other activities needed to implement the bill's other requirements in a timely fashion to meet the ambitious program deadlines prescribed in this bill or what the associated costs will be. We do not know the consequences if the deadlines are not met. If the Secretary believes that her resources are not adequate to meet the bill's challenges, what does she need to do to obtain the resources she believes necessary to fulfill her responsibilities outlined in this bill?

Another major over-arching issue dealing with responsibility for regulation and oversight that has not been fully aired in committee is that of the regulation of employer provided health plans. These plans are now regulated by the Department of Labor. The committee bill gives the regulatory responsibility of employer health plans

to the Secretary of Health and Human Services with some enforcement authority given to the Secretary of Treasury. We have not heard the Administration's view on these changes and other specific changes proposed in the committee bill.

One set of provisions in particular, the enforcement of non-discrimination rules for private health care plans, should give the Ways and Means Committee pause. Without some modification, these new rules will likely meet the untimely fate of their infamous predecessor—section 89 of the tax code—which was repealed in 1989 after years of bitter struggle. The section 89 provisions were repealed because they were unworkable and unenforceable. Why won't these new more complex non-discrimination policies have the same enforcement problems?

A fundamental premise of the bill is that the health care community and employers are basically evil, and are not to be trusted. Insurers, physicians, medical product manufacturers, and regular employers are subject to numerous rules and harsh penalties (many of them overly-broad). The bill establishes 29 separate penalties for infractions, ranging from a 25% excise tax on wages paid to an employee, to various civil monetary penalties of different sizes. To cap it all off, the bill establishes a private right of action to expose anyone subject to a civil monetary penalty to a host of lawsuits. Such extensive rules and penalties will tend to freeze the health provider community in its tracks—with many cautious about what they do, innovation necessary to improving quality and efficiency will suffer.

The committee's bill, in effect, criminalizes common business practices which otherwise would improve quality of care and reduce costs.

For example, a hospital could no longer hire a referring physician to be its medical director or to develop a new service or protocol. A hospital providing employees with free parking or reduced price meals in the cafeteria could also be found in violation of the law. Health fairs at work sites or shopping malls, screening programs, educational talks in senior citizen centers or elementary schools, courtesy transportation, etc., are frequently offered by providers as a public service; they are laudable programs that should be encouraged. Unfortunately, the Ways and Means Committee's bill will have the effect of making these practices unlawful because they may cause an individual to choose to obtain services from a provider who participates in such a program.

SUMMARY AND CONCLUSIONS

The committee's Republicans continue to strive for a rational approach to health care reform. We believe that health care reform should not be delayed. We also believe that health care reform should proceed responsibly, allowing markets to adjust as reform proceeds. Orderly change will minimize disruption and allow time for evaluation of the changes we are making. For example, we can learn from the varied and sometimes negative experiences of states which have implemented health insurance reforms and apply that knowledge to determine the scope and pace of insurance reforms at the federal level.

Health care reform should reflect the needs, desires, and culture of the American people. Individuals and families need to have some flexibility in benefits and coverage options. Every day, Americans make major decisions about complex problems that will affect their lives and the lives of their loved ones. They are capable of understanding the complexities of health care reform and making informed choices.

Our health care reform efforts should be honest. The American people deserve to be told the truth about the nature and extent of the reforms and the real price tag. They need to be told the truth about the financing and the truth about what we know and do not know about the costs, the certainty of the cost estimates and the potential risks and consequences if the cost analysis turns out to be flawed.

Health care is not a partisan issue; health care reform should not be partisan either. There are several alternative introduced bills that Republicans support—bills which embody the reform principles the American people expect Congress to embrace. We believe that they are much closer to what our constituents have expressed they want—not what some social engineer thinks they ought to have.

We believe that an ideal set of health care reform provisions would include basic insurance reforms that would prohibit insurance companies from denying coverage because of pre-existing conditions or canceling coverage if you get sick or change jobs. The insurance reforms proposed in the bill go well beyond basic reforms. In fact, they are unworkable in the real world because they will significantly drive up costs for employers and young individuals and families. The restrictions on self-insuring and anti-managed care provisions will effectively eliminate the most promising cost control mechanisms in the private sector today. The bill's provisions effectively undermine the private sector's ability to control costs, driving them toward more government regulation and control.

Currently, many self-employed individuals and families struggle just to tread water financially. Health insurance premiums—which are not deductible to them—are often considered a luxury item. We believe that this tax fairness issue needs to be addressed as quickly as possible. We think that the issue is best handled by allowing all individuals and families not eligible for employer-sponsored insurance, including the self-employed, to receive an immediate 100% deduction for health insurance premiums.

Some of our uninsured are families that earn too little to afford insurance but do not qualify for Medicaid because they earn too much. It seems logical and more efficient to target financial assistance directly to those in need, rather than create a whole new government run health care bureaucracy which completely overturns today's health care system. A sliding scale health insurance subsidy for people with incomes up to some percentage above the poverty scale would allow millions of people, often called the "working poor," to be able to purchase insurance. We also need to balance our efforts by targeting direct health care services to those in need—through expanded community and rural health centers.

Health care reform is one of the few domestic policies that directly touches every American. No one is left unaffected, and any health care reform proposal needs to have its policies well coordinated. Its incentives need to be working together to achieve our policy goals. The potential consequences of making a major mistake with one-seventh of our economy compels us to have a well thought out, carefully analyzed bipartisan proposal.

These changes can be accomplished without raising taxes, without employer mandates, and without a new intrusive big government bureaucracy. We believe that we can fix the problems with our health care system and improve its ability to provide our people with the best care in the world. It would be a terrible mistake for the Congress to embrace instead the Clinton-Ways and Means Committee bill's commitment to end health care as we know it.

BILL ARCHER.
 PHILIP M. CRANE.
 BILL THOMAS.
 E. CLAY SHAW, Jr.
 DON SUNDQUIST.
 NANCY L. JOHNSON.
 JIM BUNNING.
 FRED GRANDY.
 AMO HOUGHTON.
 WALLY HERGER.
 JIM MCCRERY.
 MEL HANCOCK.
 RICK SANTORUM.
 DAVE CAMP.

ADDITIONAL VIEWS OF REPRESENTATIVES PHILIP M.
CRANE ON H.R. 3600 AS REPORTED OUT OF THE WAYS
AND MEANS COMMITTEE

Although I believe that there are steps that the federal government can take to contain rising health costs and expand the public's access to health insurance. I am strongly opposed to the big government approach taken in the Ways and Means Committee's health reform bill. If enacted, this proposal will destroy millions of jobs nationwide, retard the discovery of technological advancements, and give the federal government control over the health care industry which comprises one-seventh of our nation's economy.

Under the Committee's bill, all employers are mandated to pay for 80 percent of their employees' health insurance by January 1, 1998. To remain competitive in the international market, many employers will be compelled to pay for this increase in their labor costs by decreasing the size of their workforce. During our markup sessions, supporters of the Committee's bill talked at length about health care "security," but one might ask how secure Americans will feel in other aspects of their lives when they lose their jobs because of this employer mandate? Without a doubt, this legislation will take people off the lists of the uninsured and add them to the rolls of the unemployed. Last year, the Employment Policy Institute conducted a study of the impact of an employer mandate in health care reform and concluded that it would result in a loss of as many as 3.1 million jobs. More recently, the CONSAD research firm estimated that the employer mandate proposed in the Committee's bill would destroy 47,176 jobs in my home state of Illinois and would affect more than 2.4 million additional Illinois jobs. The CONSAD study further estimated that the Committee's bill would result in lost wages exceeding \$3.6 billion in Illinois.

Although the Committee's bill contains a tax credit to "ease" the burden of the employer mandate on lower wage small businesses, the structure of the tax credit will lead to dramatic changes in the economy as companies modify their business plans and organizations to qualify for the tax credit. In particular, small businesses will be discouraged from expanding beyond 50 employees and larger companies will have an incentive to spinoff their lower wage employees into separate subsidiaries in order to claim the tax credit. As a result, the tax credit will impede economic growth by discouraging expansion and will limit advancement opportunities for lower wage employees by encouraging employers to keep their wages low.

The Committee's bill also creates a Medicare Part C program for small business employers to enroll their employees in as an alternative to purchasing private sector insurance. Given the federal government's inability to contain the growth in spending on the current Medicare program as a percentage of the federal budget, I

disagree with the supporters of the Committee's bill who argue the present Medicare program should serve as the framework for health care reform. With the creation of the Medicare Part C program in the Committee's bill, however, it is likely that the majority of Americans would obtain their health insurance through a government program.

In an effort to contain health care costs, the Committee's bill threatens to impose price controls over the health care industry. Beginning in 1995, the Secretary of Health and Human Services will establish a global budget for health care expenditures in our country. Over the next several years, growth in the global budget will be reduced and linked to growth in the Gross Domestic Product. It should be noted that no country in the world has ever achieved this type of draconian limit on health care expenditures. Under the Committee's bill, however, the private sector would have to bring its health care expenditures in line with the Secretary's global budget. If the private sector in a particular state does not meet the Secretary's spending limits by 2001, the Secretary will be required to impose Medicare reimbursement rates on health care providers for the services they provide to patients with private sector insurance. Given the fact that Medicare reimbursement rates do not even cover the costs incurred by health care provider in the delivery of Medicare services, the Committee's proposal jeopardizes the availability of quality medical services and could lead to rationing by forcing health plans to limit patient access to high cost services in order to keep their expenditures low. Moreover, the specter of price controls will impede the discovery of technology advancements by discouraging investment in medical research. Furthermore, the proposal in the bill to cut federal spending on Medicare Parts A and B by \$480 billion over the next five years will exacerbate the existing discrepancy between public and private reimbursement rates and threaten the availability of health services to our nation's senior citizens.

Finally, I am opposed to the Committee's bill because it includes abortion in the national standard benefits package and mandates all Americans to pay for abortion services as part of their health insurance premiums. If enacted, the bill will, in direct conflict with the Hyde amendment, use federal funds to pay for the abortions of women enrolled in government insurance programs. In my view, abortion should not be sanctioned, and if ever permissible, should be the last resort in only the most restricted of circumstances, for example, to preserve the life of the mother. My primary concern is that human life be held superior to all other rights. Indeed, it would seem to me that regardless of one's view of abortion, everyone could agree that abortions should not be performed with involuntarily raised tax dollars. With those views in mind, it should come as no surprise that I cannot support the proposal in the Committee's bill to mandate coverage of on-demand abortion services and federal funding for abortions.

In the haste to report out a health care reform bill to our colleagues in the House of Representatives, I believe that the Ways and Means Committee has developed a package which will have a devastating impact on our economy and on the quality of health care in our country. For this reason, I am opposed to the Commit-

tee's health care reform bill. It is my hope that the defeat of this bill's approach to health care reform on the House floor will lead our Committee to reexamine this important issue and the alternatives that have been developed which would strengthen the free market's ability to contain health costs and expand health coverage in ways that do not enlarge the federal bureaucracy or harm the economy. In particular, I support the creation of medical savings accounts to give individuals direct control over their health care dollars by allowing them to choose the type of health services they receive. In addition, I support proposals that would increase access to health insurance for millions of Americans by providing individuals with tax credits for their health care premiums and expanding the ability of small businesses to pool their employees for the purpose of purchasing health insurance. Moreover, I have cosponsored legislation which would help to eliminate the job lock that many individuals with preexisting conditions currently experience by limiting the ability of insurance companies to refuse coverage to individuals with health problems. Furthermore, I believe that health care reform must contain malpractice reform to reduce the added cost of defensive medicine to our health system. Unlike the legislation which has been reported out of the Ways and Means Committee, these proposals would cut down the barriers to obtaining health insurance without destroying jobs and the best quality medical care that exists in the world.

SUPPLEMENTAL VIEWS TO WAYS AND MEANS COMMITTEE REPORT ON H.R. 3600 7-12-94

1. Abortion Coverage in the Committee Bill

The expansion of abortion coverage in this bill is radical and dangerous. The Committee bill not only calls for the dramatic expansion of abortion in this country, it eviscerates the Hyde Amendment and forces every American to purchase abortion insurance—whether they want it or not. In short, this bill places an abortion mandate on the American people.

The proponents of the abortion language in the committee bill claim that they are only protecting the status quo and the choices that Americans now have. This is simply not true.

The committee bill mandates that every American pay up to 20% of the cost toward the purchase of health insurance that covers a basic set of benefits and procedures. One of the procedures covered in this minimum benefits package is abortion. In short, no matter what personal or moral convictions an individual holds, they are ordered by the government to help pay for abortion insurance under this bill.

Furthermore, the bill also mandates that businesses pay at least 80% of the cost of their employee's health insurance coverage. Like employees and non-working Americans, every employer must contribute toward the purchase of insurance that includes abortion. This means that Catholic hospitals or other groups that are morally or otherwise opposed to abortion are ordered under this legislation to help subsidize abortion for their employees.

Finally, the committee bill completely rolls back the Hyde Amendment and provides federal funding for abortion. This legislation provides for general federal subsidies to businesses and individuals to help pay for abortion insurance. This despite the fact that since 1977 the Hyde Amendment has denied federal spending on abortions except in cases of rape, incest and danger to the life of the mother. Any claim by proponents of this bill that federal funds do not directly fund abortion or are somehow separated out from paying for abortion is simply not true.

Although a majority of my colleagues on the committee voted for the Hyde Amendment when the House last considered it in 1993, many of these same members voted this time to use federal tax dollars to help subsidize abortion. I find this both confusing and extraordinary.

While there is a so-called "Conscience Clause" in this bill that allows health care providers not to offer services such as abortion on moral grounds, this provision is merely a fig leaf to give comfort and political cover to committee members who are squeamish about the radical expansion of abortion coverage by this legislation. The "Conscience" provision gives providers the choice of whether or not

to provide a service. But even if a provider chooses not to perform a certain service, it is still incumbent on the provider to refer the patient to another provider who will perform the service.

The "Conscience" provision does not extend to employers or individuals who want to opt out of paying for coverage for abortion. No matter what an individual's or employer's personal beliefs, there is no escape for them from the abortion mandate under this legislation. Any claim to the contrary is false and either misinformed or disingenuous.

The abortion provisions in this bill do not protect the status quo or merely protect the right of individuals to opt for abortion. Instead, they mandate abortion insurance for everyone. To be blunt, this is abortion on demand.

The status quo does not mandate that every American get abortion insurance. The status quo does not provide for federal funding for abortion under practically any set of circumstances. The status quo does not order employers to help pay for abortion insurance for their employees. The status quo does not force health care providers to assist women in finding other providers that offer abortion services. This bill does not preserve the status quo. It erases it and radically expands abortion coverage to every American—whether they want it or not.

In a dangerous and misguided bill, the abortion provisions might be the most insidious of all. I am profoundly disturbed by the committee's passage of this legislation. The only glimmer of hope I see in this entire scenario is that the radical expansion of abortion in this bill is so ominous and menacing, the abortion issue is probably one of the few issues that could derail this awful bill or any of its progeny.

2. Increase in the Federal Excise Tax on Tobacco

The increase in the federal excise tax on tobacco products is patently unfair and regressive. It disproportionately hits low and moderate income people and it singles out one commodity, and one area of the country, to bear an unjust burden in paying for health care reform.

This bill is supposed to be a national health care reform plan, but it is subsidized by a devastating regional tax. To the economies of many states, and particularly my home state, Kentucky, this tax increase will be devastating.

The increase in the tobacco excise tax will ravage the economy and the way of life in Kentucky and will put thousands of people out of work. The economy, the land values, and the tax base all depend on tobacco.

Unfortunately, tobacco is not politically correct these days. The Clinton Administration is dedicated to the destruction of tobacco as a legal commodity. Tobacco is an easy target for a tax to pay for health care, but that does not make it fair and it does not make good policy.

Some argue that tobacco users should pay for the additional costs of tobacco-related illnesses. But the plain truth is that tobacco is already paying its way. Numerous reports have shown that through the current federal and state taxation of tobacco, tobacco users are already more than paying for any extra health costs that

they might incur. Even the Congressional Research Service recently reached this same conclusion.

But there is another disturbing facet to the tobacco tax increase. Many of my colleagues seem to think that they can have it both ways—they to tax tobacco to help pay for health care reform, but many of them, by their own admissions, want to kill tobacco altogether. You cannot use tobacco as the goose that lays the golden egg if you also want to kill the goose.

If you create a gargantuan government-run health care system, somebody is going to have to pay for this monster. If you kill the golden goose of tobacco, the monster is going to go looking for another bird.

Raising the tobacco tax is a dangerous precedent for any committee member who has a major industry in their district that could be seen as a health threat. Any one of a number of industries could be the goose that gets that gets targeted after tobacco is finished.

Alcohol, fatty foods, automobile emissions, red meat, oil and gas. All of these products could be described as “health-threatening” and then be taxed by the very same logicians that pushed for the tobacco tax increase. When the health care monster comes after these products, members from districts that get hit by new taxes had better not come looking for my support.

Raising the federal tobacco tax is an unfair, unsound way to fund national health care. It is bad precedent, it is illogical and it is ominous. Unfortunately, not enough of my colleagues saw things this way when the committee voted. I suspect that down the line when the shoe is on the other foot, they will make the very same arguments that I have just outlined. Sadly, like now, they will probably fall on stone-deaf ears.

ADDITIONAL VIEWS BY THE HONORABLE FRED GRANDY
(R-IA) SELF-EMPLOYED HEALTH INSURANCE DEDUCT-
IBILITY

Since joining the House Ways and Means Committee in 1991 I have argued that the deduction for health insurance purchased by self-employed individuals should be raised to the same deduction available to corporations. Corporations are able to deduct 100 percent of any health insurance premium paid on behalf of employees, no matter how generous the benefits provided under that insurance. The self-employed however have been able to deduct only 25 percent of the cost of the health insurance they purchase for themselves and their families.

This bill not only continues this discrimination against the self-employed, but it would permanently put into place a deduction of only 80 percent and that would not be effective until 1998. More than one in five self-employed individuals are uninsured and more than that are under insured because of the cost of insurance. This bill will only exacerbate this chronic problem. Cost is the biggest factor in the inability to access health insurance.

There are those who argue that the small business subsidies contained in this legislation will offset the need for a 100 percent deduction. Given the Majority's eager willingness to shave back the deduction to only 80 percent and delay that until 1998, I can only wonder how soon the small business subsidies will be sacrificed to pay for enhanced benefits in some other area of the bill.

This process began before the Ways and Means Committee even finished its work. In the name of paying for such added benefits as special tax treatment of the GHI insurance company, tax giveaways for medically underserved areas, capital financing for medical schools, and undergraduate medical education funding, the self-employed were denied the ability to deduct 100 percent of their health insurance.

This Committee has operated under a premise that the self-employed health insurance deduction should be raised beyond its status at either 0 percent deduction or its meager 25 percent deduction. At the beginning of this process the President supported a 100 percent deduction and even the Chairman's Mark proposed a full 100 percent deduction—just as corporations are able to receive. Fresh arguments were created to justify this renewed discrimination against the self-employed.

I have supported legislation to provide a limit to what are deductible health insurance costs. The "tax cap" that I endorsed would have been on any health insurance benefit above the lowest cost basic benefit package in a given area. The rationale for a tax cap is that it would force price sensitivity on the consumers of health insurance. The tax cap I supported would have applied to all health insurance plans whether purchased by a corporation, an

individual, a partnership or a sole proprietor. The same cap would have applied to all and this budget mechanism would have helped to finance the health reforms in other parts of my legislation. It would have applied to all who buy insurance and it had a market-based price sensitivity rationale. The bill that the Democrat majority of this committee is supporting would simply place an arbitrary 80 percent tax cap only on the self-employed and it was used only as a revenue raiser with no market oriented rationale.

The largest employers in this country can offer their employees first-dollar, no co-pay, no-premium, gold-plated benefits with no restriction on what is deductible. However, no matter how meager the benefits a self-employed individual is able to afford, that person will only be able to deduct 80 percent of the cost. I find this irrational.

The thousands of farmers in my Congressional District are in one of the most dangerous professions in the nation. Health insurance is absolutely vital in such an environment. In addition to farmers and ranchers, the self-employed in this nation include millions of shop keepers, craftsmen, real estate professionals, direct sellers, and professionals like doctors, accountants and lawyers. For too long these entrepreneurs have only been able to deduct either nothing or only 25 percent of their health insurance premiums. The legislation reported by the Democrat Majority on this Committee will only perpetuate this difference and further doom these entrepreneurs to less benefits than those who work for corporate America.

The revenue offset I proposed to pay for the 100 percent deduction for self-employed individuals was to include in income the wage replacement component of workers' compensation. This would place workers' compensation on the same tax status as unemployment insurance benefits, disability pensions and sick leave. I will not be surprised to see the revenue from inclusion of workers' compensation in income used later this year to pay for another program.

FRED GRANDY.

SUPPLEMENTAL VIEWS—AMO HOUGHTON TO H.R. 3600

The health care bill passed by the Ways and Means Committee represents a misguided approach to health reform in the USA. My impression is that it was propelled by three elements—first, a genuine desire to do something; second, a loyalty test to the President; and third, an attempt to build on, rather than change, the legislation orchestrated by the Subcommittee on Health.

There are four reasons why I disagree with this bill:

- (1) Timing is bad;
- (2) Cost controls are poorly conceived;
- (3) Top down, government force of mandates;
- (4) Catch all, single-payer Medicare Part C.

I will discuss briefly each of the above and suggest an alternative approach.

My real worry, however, is that all this might just be a futile exercise. I have lived with, and established, health care plans for numerous businesses all my life. My objections or suggestions, which I believe are honest ones, have been turned aside as being obstructionist.

I have a further worry. There are now three bills which will become grist for the mill—with a fourth in the offing. Two in the House, one in the Senate. Three are way off any mark that American citizens, from whom I have heard, want to embrace. Two bills are Clinton Clones (Kennedy in the Senate, Ford in the House). One is "Clinton heavy"—meaning to the left of Clinton—setting the stage for a single-payer system (Gibbons in House). The last (Moy-nihan in Senate), appears to be the only one that attempts any real balance, but is vaguely financed. The conclusion is obvious. The cake will be baked with the ingredients the four chefs shove into the oven. Few seem to care that, outside that kitchen, there are customers who want something different.

Let me discuss specifically my four objections to the Ways & Means bill:

Timing—Health Care is not Social Security. The emergency is not World War II. Today we face a situation similar to Medicare legislation in 1965—the care is outstanding; the expenditures are out of sight. The 1965 estimates of what the medicare program would cost in the 1990's were off by more than a factor of ten. Budget analyses show that on a net cost basis, Medicare Part C totals zero. Most of us want to know what's behind these new numbers.

To be fair, Members of Congress need to know how much this new program would increase federal outlays each year. As it stands, the netting process assumes that premium contributions (highly questionable) will have a dollar for dollar effect. This is not the way proper accounting procedures are used. To put it still another way, there is nothing in the spread sheets or budgetary esti-

mates which would tell us whether it is a \$5 billion program or a \$150 billion program. In a word, this is risk—in two words—high risk.

Furthermore, if there is even a ray of doubt, there is no time to test out the assumptions. A bill must be passed before the elections. Timing is everything. In this case, timing is the enemy.

Cost containment—the initial reason we in Washington have been attracted to health care centers on the soaring costs. Reagan knew this, Bush knew this, and now Clinton has suited action to the word. Yet cost containment has now found itself with a dual purpose—to control prices of those programs already in place, and to absorb new programs.

The President's original plan incorporated price controls on insurance premiums. The Committee bill substituted private sector price controls on provider services. At the last moment, an amendment was added in committee that set up a new commission that would be required to decide whether prices had spun out of control, and then to recommend that either the cost controls in the bill go into effect or propose some alternative that Congress would have to consider.

History tells us a great deal—that this approach combines the worst of all possible worlds. The legislator appears to sidestep price controls, saying only that they will kick in if needed—and to be determined by a group of wise men. In practice, think of what happens to business psychology: The control sword is raised over one's head. It can be lowered at will. The normal competitive pricing pressures cease since all competitors now know there is one thing they must not do if a price control structure is put into place—be left behind. So prices are raised in anticipation of future action, controls then kick in since the trigger level has been exceeded. The end result—prices have been raised then frozen at an unnecessarily high rate through a self fulfilling prophecy. Even Sidney Hillman, the old World War II O.P.A. boss, would blanch.

Mandates—are the last lever one pulls, not the first. Top down, government directed dictums hardly fit our so called American way—absent an emergency. As President Clinton has recently discovered at the G-7 meetings, Europe's 12 percent present employment rate is not unconnected to the government mandate approach. Secretary Bentsen has been eloquent on this issue.

If we want virtual coverage, there are other ways. This country was founded on one of them. It is called incentives. Incentives result in competition, which in turn increase service and decrease prices. It happens every day. Government's job is to nudge, create incentives, even at times threaten—not to insert itself into a market driven system. Mandates, like price controls, take away the incentives.

Finally, I asked CBO Director Reischauer, "Tell me, how do mandates work?" His answer, "With great difficulty."

Medicare Part C—sounds simple, an extension of A & B. It is intriguing. However, when one examines its implications, clearly we are on the road to a single-payer system.

All of Medicare, all of Medicaid, all of those uninsured would be lumped into Medicare A or B or C—meaning between 50%–60% of the insurable population. Tie that in with individual states' single-

payer plans, and one can see a reasonably clear road map toward something most Americans do not want.

Now on a more positive note, let me suggest another approach. First is my own bill (summary attached). It is not a definitive piece. It is an alternative. It spells out two approaches: (1) The doable, and (2) An incentive based approach which would, in time, move us toward the broadest possible coverage, without putting at risk independent business producers/people who are working to create jobs for those to whom health benefits would be available.

The basic approach is to focus on what is achievable, what is natural, rather than tackling issues where many of the top economists feel "we don't know what the hell we're doing" (a quote). Why not move into the most uncertain areas gradually and try to "read", as the government fumbles around, what business and labor are actually accomplishing. For example, in Insurance Reform—Precondition, Portability, Community rating (with an age factor), Malpractice and Health insurance alliances to help the little guy get a better deal—we can solve these issues. There is no bureaucracy. We can incorporate Cooper-like incentives for the uninsured. The problem is not the poor. Most are covered. The problem ranges mostly from the young who choose not to be insured, to those with pre-existing conditions unable to buy insurance at any price. We can deal with these problems. So to rearrange totally 14%–17% of the GNP, is pretty drastic medicine.

There are fallbacks such as other voluntary alliances, soft triggers. The frightening part is that we are not now sure who is uncovered. It is important to find out. The remedy will be very different depending on who these people are. Possibly real subsidies are required, but they can come later.

Let's do what is needed. Let's do what is possible. Let's think through carefully the implications of making significant structural shifts. Finally, I hope we could respond to health, not political, pressures.

SUMMARY

Note: This bill will be referred to the following committees: Ways and Means; Energy and Commerce; Judiciary.

1. TAX PROVISIONS

Health insurance tax credit for low-income Americans

Currently, a family, with one or more children, receives a tax credit for the cost of health insurance. The maximum credit a family can receive is \$428/year. The credit decreases as a family's income rises, and eventually phases out at \$21,000.

This bill proposes a refundable tax credit for low-income taxpayers for the cost of health insurance premiums or out-of-pocket health care expenses. The maximum credit will be \$600 for an individual and \$1,200 for a taxpayer who is married or head of the house. This tax credit phases out for a single person earning \$16,000/year or at \$32,000/year for a family.

Individual tax deduction for health costs for all taxpayers

Currently, a person receives a tax deduction for the costs of health insurance premiums and out-of-pocket health costs which exceed 7½% of that person's annual adjusted gross income.

This bill proposes to split the cost of health related expenses into two parts: cost of insurance, and cost of out-of-pocket expenses (i.e. costs not covered by insurance). Health insurance premiums will be fully deductible—not subject to the 7½% rule. Out-of-pocket expenses would remain subject to the 7½% rule.

Business tax credits

Currently, there are no business tax credits for health insurance costs.

The Houghton bill proposes four new tax credits to encourage employers to provide health insurance coverage for their employees. The credits are phased out over 5 years. The hope is that the cost of health care will come down—with the enactment of this bill—and businesses will then be better able to afford the cost of offering health insurance.

A. Small Employer Basic Health Insurance Credit.—Small businesses which begin to provide health insurance for their employees will receive a tax credit for the first five years in which they offer the health benefits. The tax credit will be equal to 25 percent of the employer's cost of the health plan for the first year, 20 percent the second, 15 percent the third, 10 percent the fourth, 5 percent the fifth, and none thereafter.

B. Managed Care Credit.—Businesses that begin to offer a managed care plan will receive a tax credit for the first five years in which the plan is offered. The credit would be equal to 25 percent of the employer's cost the first year, 20 percent the second, 15 percent the third, 10 percent the fourth, 5 percent the fifth, and none thereafter.

C. Dependent Care Credit.—Businesses that begin to offer coverage for their employees dependents will receive a tax credit for the first five years in which the coverage is offered. The credit would be equal to 25 percent the first year, 20 percent the second, 15 percent the third, 10 percent the fourth, 5 percent the fifth, and none thereafter.

D. Small Employer Purchasing Group Health Insurance Credit.—Small businesses will be encouraged to join cooperatives in buying health care plans. The cooperatives will be established by the Federal government. This will offer small businesses an opportunity to purchase health care insurance at a lower rate because they will be buying it in a larger block. If a small business does take advantage of this, it will be eligible for a 20 percent annual tax credit.

Example. These four programs can be used in conjunction with each other. For example, a small business, ABC Shop, does not have a health care plan. ABC Shop decides to offer health care to its employees (A) and the employee's dependents (C) using managed care (B) purchased through a cooperative (D). ABC Shop would receive a tax credit for each category. The first year ABC Shop would be eligible for a tax credit of 95 percent of the cost of its health care. The tax credit cannot exceed a business's total tax liability. The amount is phased out over the five year period.

Preventive care incentive

This will offer individuals/families a tax credit of up to \$250 (\$200 for those above the 15 percent tax bracket) for seeking preventive care—such as well child visits to a doctor, immunizations or cancer screenings.

The act also provides the same tax credit for doctors who choose to provide free preventive care for their patients.

RURAL INITIATIVES

There are programs currently in place to provide health care services to rural areas. But, in our opinion, they are underfunded and under-utilized. The act puts more money into and increases emphasis on these programs. Some examples:

Targets Federal dollars to qualified health centers so that they can better meet the needs of rural America.

Increases authorizations for the Area Health Education Centers. This program awards grants to rural communities so they in turn can provide stipends to health care providers to encourage them to continue providing services to rural communities.

Targets additional Federal money to train health professionals so that they can provide health care in rural areas.

Increases Federal funding for cooperative health care centers in rural areas.

Awards grants to develop networks for the sharing of health care resources and information among rural and urban health care providers to improve the quality of health care in rural areas.

3. MANAGED CARE

Managed care is a comprehensive, coordinated approach to total health care delivery. It resolves two major problems

A. Control of Unnecessary Treatment.—For example, a patient, using a managed care center, sees a doctor for a sore elbow. The doctor assesses the problem and then treats it without the patient seeing another doctor or specialist. This cuts excessive treatments and costs. If the sore elbow was something more serious, the attending doctor would have referred the patient to a specialist within the center.

B. Controls Overlapping Treatments.—For example, a patient, not in a managed care system, is seeing one doctor for a heart problem and another doctor for arthritis. The heart doctor prescribes a drug for the heart condition which might counteract a drug prescribed for the arthritis. If that patient was enrolled in the managed care center, the two doctors would be in contact with each other, and the overlapping care would not adversely affect either treatment.

Currently, a managed care program is, for the most part, regulated by the state. Each state mandates its own set of regulations—they vary from state to state. This makes it impossible for an insurance company to offer a nationwide plan. This bill establishes a board which will develop a set of standards for managed care programs across the country. Once a program meets the national standards, the various state mandates are preempted. This will

allow an insurance company to offer a nationwide plan without excessive state mandated regulations.

4. ADMINISTRATIVE COST REDUCTION

This proposes that standardized forms be developed to simplify processing of claims for reimbursements of physician, hospital and other medical services. Currently, the average family doctor's office hires more than the equivalent of one full-time employee to do nothing more than shuffle paperwork—between the patient, doctor, hospital, insurance company or Federal agency. And, on top of that, each of the hundreds of insurance providers have their own forms and reporting practices. The Houghton bill calls for a nationally standardized reporting system for all health care providers which will save billions of dollars.

5. ASSISTING SMALL BUSINESSES TO ACCESS HEALTH INSURANCE

A. *Purchasing Power.*—Purpose of this provision is to increase the ability of small businesses to provide affordable health insurance for its employees. It does so by enabling small businesses to establish purchasing groups. In other words, the businesses can cut costs by jointly purchasing health plans. Start-up grants to implement such programs, will be available through the Department of Health and Human Services. Plans purchased through an approved group will be exempt from any state mandated benefit requirement.

B. *Insurance Reform.*—Purpose is to improve the affordability of health insurance for small businesses. Under this bill, the Department of HHS will develop a model health care insurance benefits program that small businesses can implement. This plan:

Guarantees availability of such policies to small businesses wishing to purchase them.

Guarantees renewal of such policies if no reasonable cause for termination exists.

Limits rates for new policies to between 80% & 120% of the average rate for that class. (Businesses will be divided into classes based on their size.)

Limits ability of insurers to impose coverage restrictions.

Limits annual rate changes to the level of rates charged to new businesses.

6. PUBLIC PROGRAMS

This will create a new optional public health insurance program for those people not eligible for Medicaid, but below 200% of the Federal poverty level. States choosing to take part in this program will charge a total of 5% of the individual's adjusted annual gross income for premiums, deductibles, and/or co-payments. For example, a family of four making \$20,000/year would be eligible and would pay no more than 5% of \$20,000, or \$1,000/year for health care. The cost will be shared by the Federal and State governments. The maximum Federal matching benefit per person is set at \$10,000/year.

7. MALPRACTICE REFORM

Expedited settlements. This will give claimants or defendants 60 days after a complaint is filed to make an offer of settlement. If an offer is made by one side and rejected by the other, the rejecting side will have to pay all of the attorneys' fees—on both sides—if it loses.

Alternative dispute resolution. All states must develop some alternate form of dispute resolution to avoid time-consuming and costly court battles.

Uniform standards for medical malpractice. This will place limits on non-economic damages—pain and suffering—at \$250,000, regardless of the number of providers being sued. This provision will also limit an attorney's fee to 25% of the first \$150,000 and 15% of amounts exceeding \$150,000.

Uniform statute of limitations for malpractice.—A person must file a complaint within 2 years after discovering the problem, but no later than 4 years after the date it occurred.

Extra protections for emergency obstetrical services. Clear and convincing evidence will be required for proof of malpractice related to labor and delivery provided on an emergency basis if the patient was not previously treated for the pregnancy by the physician.

8. MEDICAL PRODUCTS LIABILITY REFORM

Punitive damages for medical products cannot be awarded in claims against the manufacturer or seller of a previously FDA approved drug or medical device. The only exception is if information was withheld or misrepresented on the products in question.

9. LONG TERM CARE INCENTIVES

Currently, health insurance covers acute care, but not long-term—or nursing home care. It is estimated that by the year 2030, the number of people requiring help with daily living (dressing, feeding, cleaning, etc.) will increase from 7.1 million to 13.8 million. The number of nursing home patients will also rise from today's figure of 1.5 million to 5.3 million in 2030.

This bill provides a variety of incentives to encourage people to purchase long-term health insurance now so they have coverage later. Those incentives include:

- Penalty-free IRA withdrawals to purchase long-term health care insurance;

- \$2,000 tax credit for in-home custodial care of a dependent;

- Tax deductions for long-term health care insurance (therefore, businesses can offer this as a one of their available benefits);

- Accelerated death benefit payments to the chronically and terminally ill (early pay-out of life insurance benefits); and

- Establishment of a corporation which will assist insurance companies in financing long-term health insurance programs.

10. INSURANCE PORTABILITY

This guarantees that, (A) a person who has health insurance at one company will be offered similar insurance at another company if he/she takes a position there—that is, assuming the new company does not offer

health insurance, and (B) that person or his/her dependents will be guaranteed similar health insurance regardless of pre-existing medical conditions, such as cancer or diabetes.

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